82-654

No.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

ATLAS TILE & MARBLE COMPANY and
HARTFORD ACCIDENT & INDEMNITY COMPANY
Petitioners,

v.

JAMES R. SHAHADY

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION
PROGRAMS, U.S. DEPARTMENT OF LABOR,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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QUESTIONS PRESENTED

1. Are the statutory and regulatory provisions of the Longshoremen's and Harbor Workers' Compensation Act, which require close supervision by the Director of the Office of Workers' Compensation Programs of medical treatment of injured workers, rendered inapplicable because a physician selected by the employer and insurance carrier renders an opinion that the worker is not in need of continuing medical treatment?

2. In such a circumstance, is the termination of active medical treatment by the physician to whom claimant is referred by the employer deemed to constitute a refusal or neglect by the employer to provide or authorize medical care or treatment under the Act?

LIST OF PARTIES

The parties to the case are set forth in the caption.

Petitioner is a subsidiary of International Telephone and Telegraph Corporation. Pursuant to Rule 28.1, Petitioner is affiliated with the following non-wholly owned subsidiaries:

Abbey International Corporation
Abbey Life Insurance Company of Canada
Abbey Overseas Group
Bonding and Insurance Agency & Insurance Factors, Limited
Cameron and Colby
First State Insurance Company
Four Thirty Seven Land Company, Inc.
Great Eastern Insurance Company
Hartex, Inc.
Hartford Accident and Indemnity Company
Hartford Casualty Insurance Company
Hartford Equity Sales Company, Inc.

Hartford Europe, Inc.
Hartfore Fire Insurance Company
Hartford Fund, Incorporated
Hartford Insurance Company of Alabama
Hartford Insurance Company of Illinois
Hartford Insurance Company of the Midwest
Hartford Insurance Company of the Southeast
Hartford Investment Services, Inc.
Hartford Life and Accident Insurance Company
Hartford Life and Annuity Insurance Company
Hartford Life Insurance Company
Hartford/Monitor Insurance Group
Hartford Real Estate Company
Hartford Securities Company, Inc.
Hartford Specialty Company
Hartford Variable Annuity Life Insurance Company
ITT Life Insurance Corporation
Lloyds Underwriters
London-Canada Insurance Company
Meridian 901 Corporation
New England Reinsurance Corporation
New York Underwriters Insurance Company
Nutmeg Insurance Company
One Hundred Edgewood Avenue, Inc.
Pacific Insurance Company, Limited
Prairie Lakes Investment Company
Sentinel Insurance Company, Ltd.
Terry Associates, Inc.
The Hartford Insurance Group Foundation, Incorporated
The Hartford Investment Management Company
Torrey Pines Bruno, Inc.
Tower Insurance Company of Connecticut
Translandno, Inc.
Twin City Fire Insurance Company
1810 Corporation

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v.

JAMES R. SHAHADY

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION
PROGRAMS, U.S. DEPARTMENT OF LABOR,
Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

Petitioners, Atlas Tile & Marble Company and Hartford Accident & Indemnity Company, pray that a Writ of Certiorari issue to review the order of the United States Court of Appeals for the District of Columbia Circuit entered in this proceeding on June 4, 1982.

OPINIONS BELOW

The opinion of the Court of Appeals was originally issued as a memorandum accompanying a judgment order entered on June 4, 1982 but was published at the request of the Respondent Director, Office of Workers' Compensation Programs and appears in the Appendix hereto (Appendix E, p. 7a), as do the opinion and decision of the Benefits Review Board dated June 11, 1981 (Appendix G, p. 25a), the separate opinion of Administrative Appeals Judge Miller, dissenting, dated September 21, 1981 (Appendix H, p. 38a) and the decision and order of Administrative Law Judge Robert A. Briggs, dated November 15, 1979 (Appendix I, p. 44a).

JURISDICTION

The Court of Appeals for the District of Columbia Circuit had jurisdiction under 33 U.S.C. § 921. The judgment of the Court of Appeals was entered on June 4, 1982 and petitioners motion for rehearing was denied on July 16, 1982. The petition for certiorari was filed within 90 days of the latter date. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(i).

STATUTES INVOLVED

United States Code, Title 33:

> § 907. Medical Services and Supplies.
>
> (a) The employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require.

(b) The employee shall have the right to choose an attending physician authorized by the Secretary to provide medical care under this Act as hereinafter provided. If, due to the nature of the injury, the employee is unable to select his physician and the nature of the injury requires immediate medical treatment and care, the employer shall select a physician for him. The Secretary shall actively supervise the medical care rendered to injured employees, shall require periodic reports as to the medical care being rendered to injured employees, shall have authority to determine the necessity, character, and sufficiency of any medical aid furnished or to be furnished, and may, on his own initiative or at the request of the employer, order a change of physicians or hospitals when in his judgment such change is desirable or necessary in the interest of the employee. Change of physicians at the request of employees shall be permitted in accordance with regulations of the Secretary.

(c) The Secretary may designate the physicians who are authorized to render medical care under the Act. The names of physicians so designated in the community shall be made available to employees through posting or in such other form as the Secretary may prescribe.

(d) An employee shall not be entitled to recover any amount expended by him for medical or other treatment or services unless he shall have requested the employer to furnish such treatment or services, or to authorize provision of medical or surgical services by the physician selected by the employee, and the employer shall have refused or neglected to do so, or unless the nature of the injury required such treatment and

services and the employer or his superintendent or foreman having knowledge of such injury shall have neglected to provide or authorize the same; nor shall any claim for medical or surgical treatment be valid and enforceable, as against such employer, unless within ten days following the first treatment the physician giving such treatment furnish to the employer and the Secretary a report of such injury and treatment, on a form prescribed by the Secretary. The Secretary may, however, excuse the failure to furnish such report within ten days when he finds it to be in the interest of justice to do so, and he may upon application by a party in interest, make an award for the reasonable value of such medical or surgical treatment so obtained by the employee. If at any time the employee unreasonably refuses to submit to medical or surgical treatment, or to an examination by a physician selected by the employer, the Secretary may, by order, suspend the payment of further compensation during such time as such refusal continues, and no compensation shall be paid at any time during the period of such suspension, unless the circumstances justified the refusal.

(e) In the event that medical questions are raised in any case, the Secretary shall have the power to cause the employee to be examined by a physician employed or selected by the Secretary and to obtain from such physician a report containing his estimate of the employee's physical impairment and such other information as may be appropriate. Any party who is dissatisfied with such report may request a review or reexamination of the employee by one or more dif-

ferent physicians employed or selected by the Secretary. The Secretary shall order such review or reexamination unless he finds that it is clearly unwarranted. Such review or reexamination shall be completed within two weeks from the date ordered unless the Secretary finds that because of extraordinary circumstances a longer period is required. The Secretary shall have the power in his discretion to charge the cost of examination or review under this subsection to the employer, if he is a self-insurer, or to the insurance company which is carrying the risk, in appropriate cases, or to the special fund in section 44.

(f) An employee shall submit to a physical examination under subsection (e) at such place as the Secretary may require. The place, or places [sic] shall be designated by the Secretary and shall be reasonably convenient for the employee. No physician selected by the employer, carrier, or employee shall be present at or participate in any manner in such examination, nor shall conclusions of such physicians as to the nature or extent of impairment or the cause of impairment be available to the examining physician unless otherwise ordered, for good cause, by the Secretary. Such employer or carrier shall, upon request, be entitled to have the employee examined immediately thereafter and upon the same premises by a qualified physician or physicians in the presence of such physician as the employee may select, if any. Proceedings shall be suspended and no compensation shall be payable for any period during which the employee may refuse to submit to examination.

STATEMENT OF THE CASE

On November 19, 1975, claimant James R. Shahady while employed as a marble mason with the Atlas Tile & Marble Company, a petitioner herein, was injured when he jumped from an eighteen inch high platform, fell and landed on his left knee. About one week after the injury, claimant selected and came under the care of his family physician, Dr. Benjamin Pecson, a general practitioner. Because Dr. Pecson did not submit a medical report pursuant to 33 U.S.C. § 907(c), Hartford Accident & Indemnity Company, the insurance carrier and a petitioner herein, requested claimant to see Dr. Marvin Gibson, an orthopedist who first saw Mr. Shahady on October 8, 1976. Claimant voluntarily continued to see Dr. Gibson and ultimately left knee surgery was performed on April 2, 1977. Dr. Gibson provided follow-up treatment until April 14, 1978, when Dr. Gibson discharged claimant from continuing care, although he remained available for treatment as needed. Rather than returning, however, claimant again sought treatment from Dr. Pecson, and then ultimately changed physician to Drs. Gerald Schuster and Jacob Edelson for a further operation, and follow-up care. No consent was requested from the employer, carrier or deputy commissioner in accordance with § 7(d) of the Act, nor was written authorization for the change obtained. 33 U.S.C. § 907(b); 20 CFR § 702.406.

Claimant filed a claim for benefits under the Longshoremen's and Harbor Workers' Act, as amended, 33 U.S.C. § 901 *et seq.* (1976) as extended to cover employees under the District of Columbia Workers' Compensation Act, D.C. Code § 36-501 *et seq,* seeking payment for the medical expenses of Drs. Pecson, Schuster, and Edelson.

A formal hearing was held on October 19, 1979 before

an Administrative Law Judge who denied the claim for reimbursement for medical expenses based upon three separate grounds. First, the claimant had not requested that employer authorize treatment by Dr. Pecson, as provided in Section 7(d) of the Longshore Act. 33 U.S.C. § 907(d). Second, claimant had failed to obtain a prior written consent to change physicians from Dr. Pecson to Drs. Schuster and Edelson as required by § 7(b) of the Act and 20 C.F.R. § 702.406. Third, all three physicians had failed to submit timely medical reports pursuant to the terms of Section 7(d) of the Act.

On appeal, the Benefits Review Board, one member dissenting, agreed with the decision of the Administrative Law Judge that Claimant had failed to comply with the statutory requirements, and affirmed the denial of reimbursement for the medical expenses.

Claimant then filed a petition for review in the United States Court of Appeals for the District of Columbia Circuit pursuant to 33 U.S.C. § 921(c). The Director of the Office of Workers' Compensation Programs of the United States Department of Labor, who was not named as an agency respondent in claimant's petition, moved to amend and reform the caption to be included as a respondent (although aligning himself with the claimant/petitioner). The caption of the case was reformed in accordance with a decision of the United States Court of Appeals. *Shahady v. Atlas Tile & Marble Company,* 673 F.2d 479 (D.C. Cir. 1982). (Appendix F, p. 12a)

On June 4, 1982, the Court of Appeals reversed the Benefits Review Board and the Adminstrative Law Judge and held the employer and carrier responsible for the medical bills in question. The Court of Appeals held that although Dr. Gibson testified that he would have seen clai-

mant for as long as he wanted to come, his performance of a final examination and his discharge of claimant from continuing care was conduct which should be attributed to the employer and must be construed as refusal by the employer to provide medical care. The Court held claimant entitled to reimbursement for all necessary treatment subsequently procured on his own initiative. The Court of Appeals ignored claimant's failure to comply with the statutory and regulatory procedure for changing treating physicians. It further held that this constructive refusal to provide medical treatment, made it unncessary to address claimant's failure to request medical treatment in the first place under § 7(d) of the Act. The Court also held that the Administrative Law Judge abused his discretion in refusing to excuse the failure of Shahady's doctors to comply with the Act's requirements that a report be filed with the employer within ten days following the first treatment (33 U.S.C. § 907(d)) because the BRB's own precedent allegedly "makes clear" that a constructive refusal to provide medical care excuses the failure to file timely medical reports. (Appendix E, at p. 11a)

Petitioners filed a timely Petition for Rehearing with the Court of Appeals urging reconsideration in that the decision will have the widespread effect of nullifying the specific statutory requirement that the Deputy Commissioner of the Office of Workers' Compensation Programs actively supervise and monitor the medical management of compensation claimants, and will also effectively eradicate the medical reporting requirements set forth in the Act. On July 16, 1982, the petition for Rehearing was denied by the Court of Appeals without opinion. (Appendix C, p. 5a)

REASONS FOR GRANTING WRIT

I.

To Insure that the Expressed Congressional Intent Set Forth in the Longshoremen's and Harbor Workers' Compensation Act, that the Deputy Commissioner of the Office of Workers' Compensation Programs Actively Supervise and Monitor the Medical Management of Compensation Claimants, Not Be Effectively Repealed by Adoption of A Doctrine of Constructive Refusal to Provide Medical Care.

The opinion by the Court of Appeals has adopted a judicial doctrine which removes from the protection of the statutorily-mandated duty of the Deputy Commissioner of the Office of Workers' Compensation Programs to supervise and manage medical care of injured workers, those cases in which there exist differences in medical opinion, and which are therefore the cases in most need of the Deputy Commissioner's supervisory powers. This judicial abolition of the statutory safeguards is not only contrary to the expressed intent of Congress as found in § 7 of the Act, but it establishes a precedent which holds that if an independent physician, to whom a claimant has been referred by the employer or carrier[1] renders a medical opinion that a claimant is not in need of continuing medical treatment, because the physician believes either

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[1]The Court of Appeals termed such a physician "the employer's physician," a term which appears nowhere in the Act. The employer is not bound by such a physician's finding, and would be free, if given the opportunity, to reject his advice. In this case, the employer and carrier were never given the opportunity to take a position with respect to medical care.

that he has recovered, that he has no injury in the first place, that he would not benefit from further treatment,[2] or that some similar circumstance exists, then if the claimant disagrees, he need not even ask the employer, carrier or Deputy Commissioner for additional treatment or even inform any of them that he is seeking or obtaining treatment from new physicians. Aside from the obvious setbacks which could be dealt to an employee's recovery, and the prejudice to the employer and carrier, the result will be to deprive the Deputy Commissioner of the obligation to supervise the medical management of the injured worker. Indeed in a case such as this, where medical opinions may differ, it is the Deputy Commissioner who knows the local doctors, who can best ascertain if a change is warranted and who can determine what is in the claimant's best interest; yet that expertise and power is gone forever if the worker is given free reign to go anywhere he chooses – to a physician of the wrong specialty, to a doctor handpicked by his attorney, etc. This is particularly true where the physicians are not required to file medical reports to keep the Deputy Commissioner informed.

Congress' express intent that the Deputy Commissioner exercise close supervision is strewn throughout the statute and then reflected in numerous places in the Labor Department regulations. For example, § 7(b) of the Act delegates total control over medical treatment to the Secretary of Labor:

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[2]The very condition for which the Administrative Law Judge found later treatment necessary in this case was a condition which the physician to whom the carrier referred claimant *predicted* in his final report, and as to which he later testified was causally related, a condition of degenerative arthritis. The only difference of opinion was therefore one of medical judgment as to what treatment, if any, was appropriate at that time, not whether claimant had a continuing medical condition.

> The Secretary shall *actively supervise* the medical care rendered to injured employees, shall require periodic reports as to the medical care being rendered to injured employees, *shall have authority to determine the necessity, character, and sufficiency of any medical aid* furnished or to be furnished, and *may, on his own initiative or at the request of the employer, order a change of physicians* or hospitals when in his judgment such change is desirable or necessary in the interest of the employee. Change of physicians at the request of employees shall be permitted in accordance with regulations of the Secretary.

22 U.S.C. § 907(b) (emphasis added) This power has been assigned by the Secretary to the Director, O.W.C.P., and in turn to the Deputy Commissioners:

> § 702.407 Supervision of medical care
>
> The Director, O.W.C.P., through the deputy commissioners and their designees, *shall actively supervise the medical care* of an injured employee covered by the Act. Such supervision shall include:
>
> (a) The requirement that periodic reports on the medical care being rendered be filed in the Office of the deputy commissioner, the frequency thereof being determined by order of the deputy commissioner or sound judgment of the attending physician as the nature of the injury may dictate;
>
> (b) The determination of the necessity, character and sufficiency of any medical care furnished or to be furnished the employee;
>
> (c) The determination of whether a change of physicians, hospitals or other persons or locales

> providing treatment should be made or is necessary;
>
> (d) The further evaluation of medical questions arising in any case under the Act, with respect to the nature and extent of the covered injury, and the medical care required therefor.

20 CFR § 702.407. The primary purpose for these administrative powers is to benefit the employee – to protect him from unnecessary or questionable medical treatment. It also provides the employer and carrier with the ability to closely monitor their statutory rights and obligations and allows the Deputy Commissioner the ability to rid the system of abuses.

The Secretary's obligation to be kept current on all medical treatment is demonstrated by the statutory and regulatory ten-day reporting:

> . . . nor shall any claim for medical or surgical treatment be valid and enforceable, as against such employer, unless within ten days following the first treatment the physician giving such treatment furnish to the employer and the Secretary a report of such injury and treatment, on a form prescribed by the Secretary.

33 U.S.C. § 907(d). See also 20 CFR § 702.422.

The employer and carrier have a direct right to obtain medical examinations, and the employee may lose some of his compensation benefits for failure to comply:

> If at any time the employee unreasonably refuses to submit to medical or surgical treatment, or to an examination by a physician selected by the employer, the Secretary may, by order, suspend the payment of further compensation during such time as such refusal con-

> tinues, and no compensation shall be paid at any time during the period of such suspension, unless the circumstances justified the refusal.

33 U.S.C. § 907(d).

The Secretary is empowered by statute to conduct his own medical investigation, after which the employer and carrier have a statutory right to reexamination. 33 U.S.C. § 907(e). The regulations promulgated thereunder set forth specific procedures to be followed, particularly where medical issues are raised or medical opinions are disputed. 20 CFR § 702.408, 409.

Congress specifically empowered the employer to request the Secretary to change physicians, while leaving it to the Secretary to promulgate regulations pertaining to an employee's request to change physicians 33 U.S.C. § 907(b). The regulations promulgated by the Secretary permit a change of physician at the employee's request only where the employee has obtained the *prior written consent* of the employer, carrier or Deputy Commissioner. 20 CFR § 702.406.

Therefore, not only does the plain language of § 7(b) and (d) of the Act mandate a holding that a claimant must first request medical care from the employer in order to recover for medical expenses incurred and, thereafter, comply with reporting requirements and the procedure for change of physician, but the other statutory and regulatory provisions make it inconceivable that Congress intended to permit a claimant to recover for medical expenses which he sought on his own and as to which the Secretary, employer and carrier have had no opportunity to investigate or oversee.

The rationale behind Congress' requirement that an employee must first request authorization in order to ob-

tain payment for medical expenses is simple. The Act is set up not as a health insurance program whereby claims are presented for payment after the fact, but a program in which the Deputy Commissioner and insurance carrier play active and continuing roles in the ongoing medical treatment of a claimant. The requirement of a prior request for medical service has the dual effect of permitting the Deputy Commissioner to exercise its statutory duty to actively oversee medical care as well as to permit the carrier to assert its rights under the Act, with actual knowledge of a claimant's medical situation.

The Court of Appeals' opinion has negated both the statutory requirements and the detailed procedures set forth in the regulations in cases in which disputes arise concerning medical treatment. The Court's holding that Doctor Gibson's medical determination to discharge claimant from continuing active medical care equates to constructive refusal by the *employer* to provide medical care is tantamount to holding that the statutory and regulatory provision empowering the Deputy Commissioner to resolve medical disputes need never be brought into play because an employee may seek medical treatment on his own without complying with the statute whenever a dispute has arisen.[3]

---

[3]Again the Court of Appeals' designation of Dr. Gibson as "employer's physician" and its attribution to the employer of Dr. Gibson's conduct find no basis in the law of agency and ignores the independent nature of Dr. Gibson's practice. This is not a case arising prior to the 1972 amendments wherein an employee was bound to obtain treatment from a physician chosen by the employer, nor is Dr. Gibson a "house doctor." Rather, the claimant here could freely choose whether he wished to be treated by Dr. Gibson or by his initial free choice treating physician. There exists therefore no basis for the Court of Appeals' assertion that Dr. Gibson's medical judgment binds the employer and constitutes a constructive refusal of the employer to provide medical care.

The effect of the "constructive refusal" doctrine on other cases under this Act would likely be pervasive. In the majority of claims, medical treatment is routine and requires only limited monitoring by the Deputy Commissioner and carrier. In cases of complex or more unusual medical treatment, where there is often room for a legitimate difference of medical opinion, the employer and carrier have a statutory right to have a claimant examined by an independent physician of their choosing. 33 U.S.C. § 907(d). If that physician is in agreement with the course of treatment prescribed by the treating physician, then again the administrative monitoring need only be perfunctory. It is in cases in which the independent examining physician selected by the employer calls into question the nature, type or extent of treatment that the extensive administrative duties of the Deputy Commissioner are called directly into play and are of most importance. It is precisely this group of cases, which have the greatest need for active supervision by the Deputy Commissioner, in which the Court of Appeals' judicial legislation handcuffs the Deputy Commissioner's impartial invocation of the medical treatment provisions of the Act and eliminates the necessary supervision. Where a physician selected by the employer reports that there is no continuing disability from the injury, or that no additional medical treatment is needed, or where the physician himself does not undertake to perform treatment (for whatever reason), the decision below holds that a claimant need not comply with § 7(d) of the Act to request medical treatment at the outset, or with § 7(b) to request a change in physician thereafter, or to have any subsequent physician submit medical reports as required by § 7(d). 33 U.S.C. § 907(b) and (d). Where the question is one of proper medical management, as here, then under the Court of Appeals' analysis the issue would not be presented to the Deputy Commissioner as

statutorily required, but would be removed from the supervision of the Deputy Commissioner and be decided by claimant, his counsel and/or an unlimited number of future unknown physicians consulted only by claimant. For every individual who receives beneficial medical treatment on his own, many may fall prey to unscrupulous, unnecessary or repetitive medical treatment the Act was designed to guard against. The Deputy Commissioner's proper role represents the striking of a balance which preserves certain safeguards for employers and carriers under the Act, and protections designed into the Act for a claimant who may be particularly susceptible to unnecessary and overly aggressive medical care.

Because the factual situation of this case is not at all uncommon, the decision will have a widespread effect of nullifying the specific statutory requirement that the Deputy Commissioner of the Office of Worker's Compensation Programs actively supervise and monitor the medical management of compensation claimants. The choice between several potential courses of medical treatment should not be made on a retroactive basis once a course of treatment has been followed, but should be addressed by the Deputy Commissioner at a time in which the Deputy can act in the claimant's interest. An example of the effects of the opinion below is set forth in the recent Benefits Review Board case of *Lloyd v. Slattery Association, Inc.*, ____BRBS ____, BRB No. 80-515 (September 30, 1982) in which the Board apparently felt constrained to follow *Shahady* in the D. C. Circuit. Board member Kalaris in a concurring opinion convincingly explains that her concurrence is based upon her duty to follow the Court of Appeals in the D.C. Circuit despite her conviction that it is wrong. (Appendix J, p. 51a)

The decision below operates fundamentally to eliminate

the procedural requirements where a change of treating physicians is desired and will effectively eradicate the medical reporting requirements set forth in the Act. Because such a result is contrary to the intent of Congress is establishing the statutory scheme pertaining to medical care under the Act, and will have a potentially widespread negative impact on numerous other pending cases, this Court should review the decision of the U.S. Court of Appeals for the District of Columbia Circuit.

II.

To Settle an Important Question of Federal Law Which Has Not Been, But Should Be, Settled by This Court:

Does the opinion of a physician suggested by employer and voluntarily agreed to by a claimant, that the worker is not in need of continuing active medical treatment, constitute constructive refusal by the employer to furnish medical care under the statute where the employer never receives a request for medical care from the claimant and claimant never requests a change of physician under the procedure set forth in the Act?

The issue of whether a claimant's failure to comply with the Act's requirements for switching doctors for further medical care or the requirement to file medical reports should be excused under a newly created doctrine of constructive refusal to provide medical care is an important issue of federal law which has not been addressed by this Court. It should be noted that the Federal Respondent, Director, Office of Workers' Compensation Programs, has underscored the importance of the issues in this case initially by seeking party status while this case was on appeal and actively participating in briefing and arguing the involved issues. To again underscore the importance

with which the Director views this case, the Director requested the Court of Appeals to publish the decision which had originally been issued as an unpublished memorandum accompanying a judgment order. (Appendix A, p. 1a; Appendix E, p. 7a, footnote *)

Although the issues at stake have never been addressed by this Court, the Court of Appeals of several Circuits have stressed the importance of compliance with the terms of § 7 of the Act. In the case of *Maryland Shipbuilding & Dry Dock Company v. Jenkins,* 594 F.2d 404 (4th Cir. 1979), the Fourth Circuit reversed an award of medical expenses due to the claimant's failure to comply with § 7 of the Act. The Court focused on the importance of permitting the Secretary of Labor the opportunity to supervise medical care under the provisions of the Act. Although recognizing that the Act should be interpreted liberally, the *Jenkins* court held that "when claimant declined to request his employer to furnish additional medical services or to authorize such services, he failed to bring himself within the coverage of the Act." *Id.* at 406. The 4th Circuit also alluded to the failure of the physician to submit his report within ten days under the terms of § 7(d) and 20 CFR § 702.422, finding no evidence in the record sufficient to excuse the failure to file this report under regulation § 702.422(b). The Ninth Circuit has also denied recovery for medical expenses where a claimant failed to comply with the terms of the Act. *Nardella v. Campbell Machine,* 525 F.2d 45 (9th Cir. 1975). The *Nardella* Court specifically refused to disregard the plain terms of the Act under the guise of liberal interpretation. The *Jenkins* and *Nardella* holdings were entirely consistent with the holding of the Benefits Review Board below.

In a similar case, *Jackson v. Navy Exchange Service Center,* 9 BRBS 437 (1978), the Benefits Review Board also

denied reimbursement for medical expenses for failure to comply with § 7 of the Act. The Board found that the claimant's failure to request further medical treatment deprived the employer of the opportunity to respond and hence cannot be deemd and employer's refusal to provide medical care:

> Neglect only takes place after there is an opportunity to provide care. Before an employer could be said to have neglected to provide care, there must first have been a request for such care.

9 BRBS at 439.

The Court of Appeals in the instant case, however, cited none of the foregoing precedent, but rather purported to adopt the Fifth Circuit opinion in *Atlantic & Gulf Stevedores, Inc. v. Neuman,* 440 F.2d 908 (5th Cir. 1971). Its unexplained application of *Neuman* to this case should be reviewed and reversed for two separate reasons. Of supreme importance is that the opinion below adopted the *1971* Fifth Circuit case without discussion of the 1972 amendments to the Longshore Act which erected a far different statutory foundation upon which the medical expense issues must be determined. The amendments added specific provisions to the section pertaining to medical treatment to meet the concerns the Fifth Circuit expressed in *Neuman,* including giving a claimant the right to select an initial treating physician. Regulations authorized by the Act's amendments were promulgated in September, 1973, which set forth the appropriate procedures for selection and change of physicians. 33 U.S.C. § 939(a); 20 CFR § 702.401, *et seq.* In *Newman, supra,* the claimant was *limited to treatment from an employer selected physician* and he did *not* have the *opportunity* to request a change of physicians through the Deputy Commissioner. Because the

employer and the treating physician refused to provide medical care, the claimant had no choice but to seek treatment outside the provisions of the Act. The Fifth Circuit's opinion, under pre-amendment law, then articulated an equitable means by which claimant could be reimbursed for medical care since then he had no procedure to question the medical issues. The 1972 amendments, however, granted a claimant not only the right to select his own physician initially, but also, by establishing a procedure to change physician, filled the gap which had existed in *Neuman*. The *Neuman* rationale is therefore no longer applicable and the Court of Appeals' adoption of it without discussion of the effects of the 1972 amendment was grievous error.

Equally grievously, the opinion below substantially expanded the Fifth Circuit's holding and applied it to a significantly different factual situation. In *Neuman* the employer had *actively* resisted proposed medical treatment including successfully defending against *any* medical treatment at a formal hearing. When the claimant thereafter on his own initiative obtained a laminectomy, which proved the employer's litigation position erroneous, he was granted a modification of the prior award by the Deputy Commissioner. The adamant position taken by the employer in *Neuman* cannot colorably be compared to the facts in this case, where neither the claimant nor his attorney *ever asked the employer or carrier* to approve or disapprove additional care.

Here, under the Act's 1972 Amendments and the Labor Department regulations, the claimant had the inital right to select *his own* treating physician. Since he had that first free choice and had the further right to obtain a change of physician as appropriate by obtaining the prior written consent of the employer, the carrier or the Deputy Com-

missioner, he was protected from being arbitrarily locked into a physician selected by employer. It is undisputed in the present case that claimant had the opportunity to and did in fact select his own treating physician, Dr. Benjamin Pecson, to treat him for his work injury and the Administrative Law Judge so found. It is likewise undisputed that no contact was ever made with the employer, carrier or Deputy Commissioner by claimant or his attorney either to request medical treatment initially or to request a change in physician from his initial free selection at a later time.[4]

Because the 1972 amendments addressed the very concerns of the *Newman* court, and because the active refusal by the employer in *Neuman* differs substantially from this case, the Court of Appeals' decision below, adopting a doctrine of constructive refusal to provide medical care, will have the widespread effect of nullifying the statutory provisions designed to govern the medical treatment of injured workers under the Longshoremen's and Harbor Worker's Compensation Act. The Director, O.W.C.P., has below on several occasions stated that this issue is one of extreme importance. It is truly of substantial importance that this Court address the issues involved in this case and reinstate the plain statutory language.

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[4]Again, claimant had a freely chosen treating physician in this case, Dr. Pecson, but never sought authorization to change from *Dr. Pecson to Dr. Schuster,* the orthopedist who performed the ultimate surgery. The change of physicians had nothing to do with Dr. Gibson. This point was not discussed by the Court below.

III.

The Court of Appeals' Decision Below Has So Far Departed From the Accepted and Usual Course of Judicial Proceedings As To Call For an Exercise of This Court's Power of Supervision:

Even assuming that the actions of the employer-designated physician amounts to constructive refusal of the employer to furnish medical care under the statute, would such a constructive refusal eliminate the medical reporting requirements under Section 7(d) of the Act?

The Court of Appeals held that where a physician to whom a claimant has been referred by the employer has advised claimant that he is in need of no further treatment, no future physician consulted by claimant need ever report to the employer, carrier or Deputy Commissioner pertaining to ongoing treatment. This latter holding failed to discuss the consequences of unmonitored and unreported treatment or the policies giving rise to the statutory and regulatory provisions relating to reporting and monitoring medical treatment. Rather than addressing what the law should be in the District of Columbia Court, the Court of Appeals adopted this position simply by reference to the fact that the Benefits Review Board had previously discussed the issue and remanded the case for a discretionary determination of *whether* refusal to provide further medical care excused reporting. *Buckhaults v. Shipper's Stevedore Company,* 2 BRBS, 277, 280 (1975).

It is respectfully submitted that the Court of Appeals should have addressed these issues directly and determined whether or not an alleged constructive refusal to provide medical treatment should have any effect upon the Act's reporting requirements for later physicians rather than merely deferring to a prior decision of a lower judicial

body. If the Court determined that the rationale of *Buckhaults* was to be followed, it would be appropriate to set forth a detailed explanation of why constructive refusal would have any effect on medical reporting, particularly in light of the fact that such a decision represents a radical departure from the terms of the statute and regulations. This failure to confront the issue directly is even more egregious in light of the fact that such a holding would excuse the filing of reports *only* in cases in which disputes have arisen and which therefore present *a greater* need for close supervision. It is again the cases in which a dispute arises in which the Deputy Commissioner has the greatest need to be kept fully informed. To excuse the failure to report in such cases eradicates the only means which the Deputy Commissioner has to supervise treatment; yet discussion of these issues is absent from the Appeal Court's total deferral to *Buckhaults.*

Of perhaps more fundamental concern is the fact that the Benefits Review Board case to which the Court of Appeals totally defers does not even stand for the proposition for which it was cited. The Court of Appeals erroneously interpreted *Buckhaults* as holding that a constructive refusal to provide medical care constitutes an absolute defense to the failure to file later medical reports. In fact *Buckhaults* merely remanded the case for the Administrative Law Judge to address that issue and did not render a holding on it. This point was forcefully raised in the concurring opinion in *Lloyd v. Slattery Association Inc., supra,* set forth in the Appendix hereto, wherein Board member Kalaris felt constrained to reverse a denial of medical benefits based upon the Court of Appeals' decision in this case notwithstanding the Court of Appeals' erroneous interpretation of prior Board precedent. We now have a rule of law which the Board feels bound to follow,

yet *the rule of law has never been enacted as statute or held judicially in any proceeding.*

The Court of Appeals' adoption without discussion of a lower court opinion for a proposition for which the case does not even stand constitutes such a gross deviation from the usual and accepted course of judicial proceedings as to require this Court's exercise of supervision.

CONCLUSION

No prior decision of this Court has addressed the issues raised in this case. The Court of Appeals' opinion will have an enormous effect upon the administrative management of medical care under the Act. The Court of Appeals' reversal will obviously be deemed binding on the Benefits Review Board, and it will not only have to note the reversal, but will be required to adopt and cite the opinion in later cases in the D.C. Circuit, although presumably holding to its own view of the law in the other circuits. The Benefits Review Board has in fact already cited its *Shahady* opinion in later cases, which may now need to be retracted. *E.g. Betz v. Arthur Snowden Company,* 14 BRBS 805 (1981); *Shell v. Teledyne Mobile Offshore Inc.,* 14 BRBS 585 (1981).

Because the Court of Appeals' decision adopted *Neuman* and *Buckhaults* without appropriate analysis and failed to take into account either the effect of the 1972 amendments or the ramifications of its decision, this Court should grant certiorari and eliminate this unsettling and dangerous holding.

For the reasons set forth above, it is respectfully submitted that this Petition for a Writ of Certiorari should be granted.

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 81-1818 September Term, 1981

James R. Shahady,

Petitioner

v.

Atlas Tile & Marble Company
and
Hartford Accident & Indemnity Co.,
and
Director, Office of Workers' Compensation Programs,

Respondents

United States Court of Appeals
for the District of Columbia Circuit

FILED Jul 22 1982

GEORGE A. FISHER
Clerk

BEFORE: MacKinnon, Edwards and Ginsburg, Circuit Judges

ORDER

Upon consideration of respondent's (Director, Office of Workers' Compensation Programs) motion for reconsideration of decision not to publish memorandum opinion, it is

ORDERED, by the Court, that the aforesaid motion for reconsideration is granted. The memorandum opinion will

be published and the Clerk shall take such action as is necessary to bring this about.

Per Curiam
FOR THE COURT:

/s/
GEORGE A. FISHER
Clerk

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 81-1818 September Term, 1981
ARGUED 5-17-82

James R. Shahady,

Petitioner

v.

Atlas Tile & Marble Company
and
Hartford Accident & Indemnity Co.,
and
Director, Office of Workers' Compensation Programs,

Respondents

United States Court of Appeals
for the District of Columbia Circuit
FILED Jul 16 1982
GEORGE A. FISHER
Clerk

BEFORE: Robinson, Chief Judge; Wright, Tamm, MacKinnon, Wilkey Wald, Mikva, Edwards, Ginsburg and Bork, Circuit Judges

ORDER

Respondents' suggestion for rehearing *en banc* has been circulated to the full Court and no member of the Court has requested the taking of a vote thereon. On consideration of the foregoing, it is

ORDERED by the Court *en banc* that the aforesaid suggestion is denied.

Per Curiam
FOR THE COURT:

GEORGE A. FISHER
Clerk

BY: /s/
Robert A. Bonner
Chief Deputy Clerk

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 81-1818 — September Term, 1981
ARGUED 5-17-82

James R. Shahady,

Petitioner

v.

Atlas Tile & Marble Company
and
Hartford Accident & Indemnity Co.,
and
Director, Office of Workers' Compensation Programs,

Respondents

United States Court of Appeals
for the District of Columbia Circuit

FILED Jul 16 1982

GEORGE A. FISHER
Clerk

BEFORE: MacKinnon, Edwards and Ginsburg, Circuit Judges

ORDER

On consideration of respondents' petition for rehearing, filed July 2, 1982, it is

ORDERED by the Court that the aforesaid petition is denied

Per Curiam
FOR THE COURT:

GEORGE A. FISHER
Clerk

BY: /s/
Robert A. Bonner
Chief Deputy Clerk

APPENDIX D

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 81-1818 September Term, 1981

James R. Shahady,

Petitioner

v.

Atlas Tile & Marble Company
Hartford Accident & Indemnity
Company and Director, Office of
Workers' Compensation Programs,
United States Department of Labor,

Respondents

United States Court of Appeals
for the District of Columbia Circuit

FILED Jul 16 1982

GEORGE A. FISHER
Clerk

BEFORE: MacKinnon, Edwards and Ginsburg, Circuit Judges

ORDER

It is ORDERED by the Court, *sua sponte,* that the caption in the judgment and memorandum opinion issued June 4, 1982, in No. 81-1818 be, and it hereby is, amended to add the Director, Office of Workers' Compensation Programs, United States Department of Labor, as a named respondent. *See Shahady v. Atlas Tile & Marble, et al.*, No. 81-1818 D.C. Cir. February 26, 1982).

Per Curiam
FOR THE COURT:

GEORGE A. FISHER
Clerk
BY: /s/
Robert A. Bonner
Chief Deputy Clerk

APPENDIX E

Notice: This opinion is subject to formal revision before publication in the Federal Reporter or U.S.App.D.C. Reports. Users are requested to notify the Clerk of any formal errors in order that corrections may be made before the bound volumes go to press.

United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 81-1818

JAMES R. SHAHADY, PETITIONER

v.

ATLAS TILE & MARBLE COMPANY, HARTFORD ACCIDENT & INDEMNITY COMPANY, and DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, UNITED STATES DEPARTMENT OF LABOR, RESPONDENTS *

Petition for Review of an Order of the Benefits Review Board

Argued May 17, 1982
Decided June 4, 1982

Judgment entered this date

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* The caption in this case was reformed in accordance with a decision of this Court that the Director of the Office of Workers' Compensation Programs of the United States Department of Labor should be a named respondent in all Benefits Review Board review proceedings. *See* Shahady v. Atlas Tile & Marble Co., 673 F.2d 479 (D.C. Cir. 1982).

Bills of costs must be filed within 14 days after entry of judgment. The court looks with disfavor upon motions to file bills of costs out of time.

Wayne M. Mansulla for petitioner.

William P. Dale for respondents Atlas Tile & Marble Company and Hartford Accident & Indemnity Company.

Marianne Demetral Smith, Attorney, Department of Labor, with whom *T. Timothy Ryan, Jr.*, Solicitor of Labor, and *Donald S. Shire*, Associate Solicitor, were on the brief, for respondent Director, Office of Workers' Compensation Programs.

Before: MACKINNON, EDWARDS, and GINSBURG, *Circuit Judges.*

Per Curiam:[1] James R. Shahady has petitioned this court under the Longshoremen's and Harbor Workers' Compensation Act ("the Act"), 33 U.S.C. §§ 901 *et seq.*, as applied to the District of Columbia, D.C. Code §§ 36-501 *et seq.*,[2] for review of an order of the Benefits Review Board (BRB) of the Department of Labor. The BRB, with one of the three administrative appeals judges dissenting, affirmed the decision of an administrative law judge (ALJ) denying Shahady's claim against his employer and its insurance carrier for medical expenses incurred as a result of a knee injury sustained in the course of employment. Shahady maintains that he is entitled under the Act to benefits covering treatment rendered by three physicians whose services he procured after his discharge by the doctor furnished by his employer.[3] We agree.

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[1] This opinion originally issued as a memorandum accompanying a judgment order; it is published at the request of the Director of the Office of Workers' Compensation Programs.

[2] Application of the Act to the District of Columbia has now been superseded by 36 D.C. Code §§ 301 *et seq.* (1981). *See* District of Columbia v. Greater Washington Central Labor Council, 442 A.2d 110 (D.C. 1982).

[3] Petitioner clarified at argument that he does not seek benefits covering medical expenses he incurred prior to his

Under section 7(d) of the Act, 33 U.S.C. § 907(d), an employee is not entitled to reimbursement for medical treatment or services *unless* he has requested his employer to furnish or authorize such treatment or services, and the employer has refused or neglected to do so. Shahady testified that he requested further treatment from Dr. Gibson, the surgeon who attended to his knee injury pursuant to the reference of his employer's insurance carrier. According to Shahady, Dr. Gibson told him "[he] was fine," "there was nothing wrong with [his] leg," and "to come back and see him in a year." Joint Appendix (J.A.) 91. Dr. Gibson acknowledged that he performed a final exam and discharged Shahady from continuing care, J.A. 108, but stated he would have seen petitioner for "[a]s long as he wanted to come." J.A. 107-108.

Taking into account the settled rule that in cases of this nature, "[d]oubts, including the factual, are to be resolved in favor of the employee," *Wheatley v. Adler*, 407 F.2d 307, 314 (D.C. Cir. 1968) (en banc), we conclude that Shahady's claim fits securely within judicial and BRB precedent interpreting section 7(d) to authorize benefits for necessary medical treatment an injured employee procures after discharge by an employer-furnished physician. When an employee is told by the employer's physician that "he is recovered from his injury and requires no further treatment, he has, in effect, been refused treatment by the employer," and is therefore entitled to reimbursment for all necessary treatment subsequently procured on his own initiative. *Atlantic & Gulf Stevedores, Inc. v. Neuman*, 440 F.2d 908, 911 (5th Cir. 1971). *See Buckhaults v. Shippers Stevedore Co.*, BRB No. 75-132, 2 BRBS 277 (1975); *see also Walker v. AAF Exchange Service*, BRB No. 76-185, 5 BRBS 500 (1977); *Kilson v. Sun Shipbuilding & Dry Dock Co.*, BRB No.

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treatment by the surgeon to whom he was sent by his employer's insurance carrier.

75-127, 2 BRBS 172 (1975). The BRB offered no cogent explanation for its apparent departure from this precedent.

We emphasize that the ALJ specifically found the treatment independently procured by Shahady within but a few months of Dr. Gibson's discharge "necessary" and "causally related" to petitioner's injury. J.A. 33. These findings are not disputed by the employer or its carrier; they appear irreconcilable with the ALJ's determination that Dr. Gibson's discharge of Shahady from continuing care did not operate as a refusal by the employer to provide the necessary care required under the Act. *See Washington v. Cooper Stevedoring Co.*, BRB No. 75-237, 3 BRBS 474, 479 (1976), *aff'd on other grounds*, 556 F.2d 268 (5th Cir. 1977) (misdiagnosis by the discharging physician is the "equivalent of a refusal of treatment by the employer").

We recognize that fact findings made in the administrative proceedings must be accepted unless unsupported by substantial evidence. *See Voris v. Eikel*, 346 U.S. 328, 333-34 (1953). On the record considered as a whole, however, we firmly conclude that the ALJ's determination that Shahady was not refused necessary treatment is unsupported by substantial evidence. We further conclude that, in sustaining this unsupported determination without distinguishing its own precedent pointing in the opposite direction, the BRB failed to act in accordance with basic tenets of administrative law. *See Columbia Broadcasting System, Inc. v. FCC*, 454 F.2d 1018, 1025-26 (D.C. Cir. 1971). We therefore do not reach the question whether, in the absence of a refusal attributable to the employer to provide necessary medical treatment, the Act would have required Shahady to request his employer's authorization for the medical services in question. *See* 33 U.S.C. § 907(b), (d).

Finally, the ALJ refused to exercise his statutory discretion to excuse the apparent failure of Shahady's doc-

tors to comply with the Act's requirement that a report be filed with the employer within ten days following the first treatment. 33 U.S.C. § 907(d). However, as the BRB's own precedent again makes clear, failure to file a timely report should be excused where medical services are otherwise reimbursable due to the employer's refusal to provide necessary further treatment. *Buckhaults, supra* at 280. In light of our determination that Shahady is entitled to reimbursement under section 7(d), the ALJ's refusal to excuse the report-filing lapse constitutes an abuse of discretion.

For the reasons stated, the order on review is reversed.

So ordered.

APPENDIX F

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United States Court of Appeals

FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 81-1818

JAMES R. SHAHADY, PETITIONER

v.

ATLAS TILE & MARBLE CO. and
HARTFORD ACCIDENT & INDEMNITY CO., RESPONDENTS

On Motion of Director, Office of Workers' Compensation Programs, to Amend and Reform Caption

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Argued December 3, 1981

Decided February 26, 1982

Judgment entered this date

Wayne M. Mansulla for petitioner.

William P. Dale for respondents.

Mark C. Walters, Attorney, Department of Labor, for movant Director, Office of Workers' Compensation Programs.

Before: WALD, MIKVA and EDWARDS, *Circuit Judges*

Opinion *Per Curiam.*

Bills of costs must be filed within 14 days after entry of judgment. The court looks with disfavor upon motions to file bills of costs out of time.

PER CURIAM: We decide here a discrete but important question: whether the Director of the Office of Workers' Compensation Programs ("DOWCP" or "Director") within the Department of Labor is a proper respondent to a petition for review of a decision of the Benefits Review Board ("BRB" or "Board") brought under section 21(c) of the Longshoremen's and Harbor Workers' Compensation Act ("LHWCA" or "Act"), 33 U.S.C. § 921(c),[1] when the Director aligns himself with petitioner urging reversal of the Board's order. Because the statutory scheme of the LHWCA and regulations promulgated thereunder clearly contemplate that the Secretary or his delegate shall participate as a matter of course in section 921(c) review proceedings, we hold the Director should be named a party-respondent in all review proceedings brought under section 921(c), whether or not the Director supports the Board's order. Accordingly, we grant the Director's motion to amend and reform the caption in No. 81-1818.

I. BACKGROUND

Petitioner James R. Shahady filed an administrative claim against his employer Atlas Tile & Marble and its

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[1] Section 921(c) provides, in pertinent part:

> Any person adversely affected or aggrieved by a final order of the Board may obtain a review of that order in the United States court of appeals for the circuit in which the injury occurred, by filing in such court within sixty days following the issuance of such Board order a written petition praying that the order be modified or set aside. A copy of such petition shall be forthwith transmitted by the clerk of the court, to the Board, and to the other parties, and thereupon the Board shall file in the court the record in the proceedings as provided in section 2112 of Title 28. Upon such filing, the court shall have jurisdiction of the proceding and shall have the power to give a decree affirming, modifying, or setting aside, in whole or in part, the order of the Board and enforcing same to the extent that such order is affirmed or modified.

insurance carrier Hartford Accident & Indemnity for reimbursement of medical expenses for a second knee operation following a fall Shahady suffered in 1975 while employed by Atlas Tile as a marble mason. The Administrative Law Judge denied Shahady's claim in its entirety on November 29, 1979. The Benefits Review Board affirmed on June 11, 1981, with one judge dissenting. BRB No. 79-724, Case No. 79-DCWC-252. The Director did not actively participate at either stage of the administrative proceedings. Shahady filed a petition for review on July 22, 1981, D.C. Cir. No. 81-1818, naming as respondents only Atlas Tile & Marble and Hartford Accident & Indemnity.

The Director, Office of Workers' Compensation Programs, moved on August 12 to amend and reform the caption in No. 81-1818 to add as party-respondent the DOWCP. In support, the Director relies in general on the Secretary's delegation to the Director of the Secretary's duties of implementation, administration, and enforcement of the LHWCA. Specifically, the Director relies on 20 C.F.R. § 802.410(b), which provides that the DOWCP "shall be deemed to be the proper party on behalf of the Secretary of Labor in all review proceedings conducted pursuant to section 21(c) of the LHWCA." The Supreme Court appears to have approved this regulation in *Northeast Marine Terminal Co. v. Caputo*, 432 U.S. 249 (1977). There, the Court interpreted this regulation to "mak[e] it clear that the Director of OWCP is the proper federal party in a case of this nature." 432 U.S. at 256 n.11.

The named respondents present a host of arguments in opposition to the Director's position. Respondents first announce that the Director's real intent in this case is to intervene on behalf of petitioner Shahady wthout having taken any active part in the two-step proceedings within the Department of Labor. They argue that, as a movant for leave to intervene, the DOWCP must sat-

isfy the requirement of Fed. R. App. P. 15(d) (motion shall contain a concise statement of interest of movant and grounds upon which intervention is sought), as well as notions of "respondent standing" derived from *ITO Corp. of Baltimore v. BRB*, 529 F.2d 1080, 1089 (4th Cir. 1975), *refusal to substitute Director as respondent affirmed as amplified upon rehearing en banc*, 542 F.2d 903, 906-09 (1976), *cert. denied*, 433 U.S. 908 (1977). Neither the statutory scheme nor the regulation relied on by the Director impresses respondents. They concede only that if there were to be "a federal representative on appeal" the DOWCP would be the appropriate federal representative because of his general enforcement responsibilities under the Act. Concerning the regulation, 20 C.F.R. § 802.410(b), rspondents argue that it "does nothing more than clarify who is to represent the Secretary of Labor in appropriate circumstances, not to define those circumstances." They conclude that neither statute nor regulation automatically confers upon the DOWCP the status of party-respondent in all section 921(c) review proceedings. Rather, the Director must in each case demonstrate either that the Director's participation is necessary for proper administration of the Act or that the government was a party adverse before the Board. Respondents argue that in this case, the Director can show neither and therefore, that the Director's motion to amend the caption and any other attempt to participate in the case should be denied.

In reply, the Director cites Fed. R. App. P. 15(a): "In each case the agency shall be named respondent." Although acknowledging that the drafters of Rule 15(a) did not anticipate this precise situation, the Director assumes that the premise underlying the rule—that there must be *a* federal respondent in agency review proceedings—applies here. Because *the Board* is not a proper respondent in a section 921(c) review proceeding, *McCord v. Benefits Review Board*, 514 F.2d 198 (D.C. Cir.

1975), it follows by process of elimination that the DOWCP must be the proper federal respondent.

This important procedural issue has surprisingly not yet been decided in this court despite the frequency with which we are faced with petitions for review of orders of the Benefits Review Board.

II. Discussion

At the outset we acknowledge that no authority easily disposes of this motion. The statutory scheme and regulation upon which the DOWCP principally relies do not, in so many words, resolve this issue; the Supreme Court's statement on this point is also equivocal. The legislative history is unhelpful. Finally, Rule 15(a), if it applies at all, begs the question. Thus it is not surprising that the circuits have split almost evenly as to the proper role of the Director and Board in section 921(c) proceedings.[2] We now join the majority in holding that the Director should be named as federal respondent in all cases brought under section 921(c). We do so because we are convinced that this result is not only consonant with the legislative and regulatory scheme but comports best with common sense.

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[2] The decisions of court of appeals run the entire gamut of possibilities. The Director has been held to be a proper respondent by the Third and Fifth Circuits, Krolick Contracting Corp. v. Benefits Review Board, 558 F.2d 685, 689-90 (3d Cir. 1977) (Black Lung Benefits Act only); United Brands Co. v. Melson, 569 F.2d 214, 217 (5th Cir. 1978), held to be improper by the Fourth, ITO Corp. of Baltimore v. Benefits Review Board, 542 F.2d 903 (4th Cir. 1976) (*en banc*), *cert. denied*, 433 U.S. 908 (1977), and believed to be improper by the Second, Pittston Stevedoring Corp. v. Dellaventura, 544 F.2d 35, 42-43 n.5 (2d Cir.), *aff'd sub nom.* Northeast Marine Terminals Co. v. Caputo, 432 U.S. 249 (1976). For the split over the question of the Board's role, *see* note 9 *infra*; concerning the split over whether the Director has standing to file a petition for review, *see* note 6 *infra*.

That Congress intended the Secretary to play an active role in implementing, administering and enforcing the LHWCA is manifest from a reading of the Act. *See especially*, 33 U.S.C. § 939. The Secretary has permissibly delegated this broad authority and substantial responsibility to the Director of the Office of Workers' Compensation Programs. 20 C.F.R. §§ 701.201, 701.202(a).[3] Because we believe the Director's central role in the legislative and regulatory scheme dictates in large part our result to grant the Director automatic status as federal party-respondent, we will briefly journey through the administrative and judicial review processes under the amended LHWCA and its regulations.

Claims under the Act are brought first to a deputy commissioner who, if necessary, may investigate the claim and order a formal hearing before an administrative law judge. 33 U.S.C. § 919(c), (d). Under section 939(c)(1),

> The [Director] shall, upon request, provide persons covered by this chapter with information and assistance relating to the chapter's coverage and compensation and the procedures for obtaining such compensation and including assistance in processing a claim. The [Director] may, upon request, provide persons covered by this chapter with legal assistance in processing a claim. The [Director] shall also provide employees receiving compensation information on medical, manpower, and vocational rehabilitation services and assist such employees in obtaining the best such services available.

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[3] *But see* 20 C.F.R. § 1.2(d) ("[T]he Assistant Secretary has delegated authority and assigned responsibility to the Director, OWCP for the Department of Labor's programs under the following statutes: . . . (d) Longshoremen's and Harbor Workers' Compensation Act . . . *except 921 as it applies to the Benefits Review Board.*") (emphasis added). The language of this regulation openly conflicts with 20 C.F.R. § 802.410. We disregard the earlier regulation to the extent § 802.410 negates it.

Should a formal hearing be held, the Director (represented by the Solicitor of Labor) may appear and participate as "an interested party" as a matter of right. 20 C.F.R. § 702.333.

The Benefits Review Board is "authorized to hear and determine appeals raising a substantial question of law or fact taken by any party in interest from decisions with respect to claims of employees under this chapter and the extensions thereof." 33 U.S.C. § 921(b)(3). The Secretary's regulations make it clear that the Director is considered a party before the Board, whether or not the DOWCP actively participated in any formal hearing, and whether or not the Director is adversely affected thereby. 20 C.F.R. § 802.201(a) ("Any party adversely affected by a decision or order pursuant to [the LHWCA] may appeal . . . to the Board by filing a notice of appeal . . ."), *id.* § 801.2(10) (defining "party" as "the Secretary or his designee *and* any person or business entity *directly* affected by the decision or order from which an appeal to the Board is taken." Emphasis added.).

Review of final orders of the Board is had in the appropriate court of appeals upon the timely filing of a petition for review by "any person adversely affected or aggrieved" by such order. 33 U.S.C. § 921(c).[4] The Act, somewhat ambiguously, provides as well that

> Attorneys appointed by the Secretary shall represent the Secretary, the deputy commissioner, or the Board in any court proceedings under section 921 of this title or other provisions of this chapter except for proceedings in the Supreme Court of the United States.

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[4] *See* note 1 *supra*. The Secretary's regulation provides that only a *party* adversely affected or aggrieved by the order of the Board may file a petition for review. 20 C.F.R. § 702.410(a).

33 U.S.C. § 921(a). The Secretary's regulation, however, specifically states that

> The Director, OWCP as designee of the Secretary of Labor responsible for the administration and enforcement of the [Act], shall be deemed to be the proper party on behalf of the Secretary of Labor in all review proceedings conducted pursuant to section 21(c) of the LHWCA.

20 C.F.R. § 802.410(b). We believe the Secretary's regulation to be a clear and definite statement, consistent with the intent of the Act to allow the Director (as the Secretary's delegate) to participate at each stage of administrative and judicial review in order to ensure proper and consistent administration of the Act.[5]

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[5] We read § 921a simply to indicate that attorneys within the Department of Labor should represent Department officials involved in § 921(c) review proceedings, be it the Secretary (Director), deputy commissioner, or Board. Before the 1972 amendments, claims were brought before deputy commissioners. Judicial review was had by writ of injunction against the deputy commissioner in district court, with a right of appeal to the court of appeals. 33 U.S.C. § 921 (1970); DOWCP v. National Van Lines, 613 F.2d 972, 976 n.1 (D.C. Cir. 1979), *cert. denied*, 448 U.S. 907 (1980). The United States Attorney in the judicial district in which the case was pending represented the Secretary or deputy commissioner in district court and on appeal where either was a party to the case or an interested party. 33 U.S.C. § 921a (1970). *See* United Brands Co. v. Melson, 569 F.2d 214, 216 (5th Cir. 1978) (single-judge panel) (citing § 921a as evidence that the LHWCA "appears to contemplate government participation in review litigation"), Pittston Stevedoring Corp. v. Dellaventura, 544 F.2d 35, 42-43 n.5 (2d Cir.) (dictum) (same), *aff'd sub nom.* Northeast Marine Terminal Co. v. Caputo, 432 U.S. 249 (1976). *But cf.* Prolerized New England Co. v. Benefits Review Board, 637 F.2d 30, 40-41 (1st Cir. 1980) (denying without prejudice DOWCP's motion to dismiss Board as party-respondent: "[T]he idea that the Board would appear in review proceedings under § 921 evidently was not wholly foreign to Congress, since at the same time it

This court has previously held that the Director's general supervisory and enforcement interest, apart from any pecuniary interest, is sufficient to confer upon the Director standing to file a petition for review under section 921(c). *DOWCP v. National Van Lines*, 613 F.2d 972, 977 n.6 (D.C. Cir. 1979), *cert. denied*, 448 U.S. 907 (1980).[6] We hold today that this interest as expressed in the legislative and regulatory scheme, and especially in 20 C.F.R. § 802.410(b), entitles the Director to participate as party-respondent as a matter of course in all section 921(c) petitions.[7] We note that the only state-

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created the Board, Congress amended § 921a . . . ."), *cert. denied*, 101 S. Ct. 3080 (1981); ITO Corp. of Baltimore v. Benefits Review Board, 542 F.2d 903, 906 (4th Cir. 1976) (*en banc*) (§ 921a begs the question), *cert. denied*, 433 U.S. 908 (1977).

The Secretary's regulation is the only sensible construction of the current § 921a in light of this and other courts' holdings that the Board (and a fortiori the deputy commissioner) is an improper respondent. *See* McCord v. Benefits Review Board, 514 F.2d 198 (D.C. Cir. 1975), and cases cited at note 9 *infra*.

[6] *Cf.* DOWCP v. Eastern Coal Corp., 561 F.2d 632, 645 (6th Cir. 1977) (administrative interest of Director in enforcing Black Lung Benefits Act sufficient to confer standing); DOWCP v. Alabama By-Products, 560 F.2d 710, 715-17 (5th Cir. 1977) (same); DOWCP v. Peabody Coal Corp., 554 F.2d 310, 332-38 (7th Cir. 1977) (same). *Contra* DOWCP v. Bethlehem Steel Corp., 620 F.2d 60, 63 (5th Cir. 1980) (no administrative interest in litigating issues concerning proper allocation of burdens of proof and persuasion under LHWCA); Fusco v. Perini North River Assocs., 601 F.2d 659, 660 (2d Cir. 1979) (no administrative interest under LHWCA), *vacated and remanded on other grounds*, 444 U.S. 1028 (1980); DOWCP v. Donzi Marine, Inc., 586 F.2d 377, 381-82 (5th Cir. 1978) (no administrative interest under LHWCA; distinguishes Black Lung Benefits Act cases).

[7] Two possible objections that come to mind may be quickly dismissed. First, the DOWCP did not actively participate at either stage of the administrative proceedings, although entitled to do so by regulation. Generally, failure to participate

ment of the Supreme Court on point, *Northeast Marine Terminal Co. v. Caputo*, 432 U.S. 249, 256 n.11 (1976), while dictum and not entirely unambiguous, is basically in accord with our holding.[8]

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before the agency is fatal to one who seeks to participate on appeal. But that rule is inappropriate here. As a practical matter, it would be impossible for the DOWCP, with its limited resources, to actively participate before the ALJ and BRB in every case. It would be grossly inefficient to require the DOWCP to participate at the agency level in order to participate in the court of appeals, or even to move to intervene where not made a party. In any event, we believe Congress intended the Secretary's designate to participate in administrative and judicial proceedings where and when he believed it necessary.

Second, it may at first blush seem illogical to allow a respondent to side with petitioner. This is often the case, however, where the United States as statutory respondent argues on behalf of petitioner in urging reversal of some agency action. The prospect of a caption reading "DOWCP, et al. v. DOWCP, et al." can be avoided simply by the Director refraining from naming itself as respondent in any petition for review he chooses to file.

[8] *Northeast Terminal* came up on certiorari to the Second Circuit, where the Director—at that time without the benefit of 20 C.F.R. § 802.410(b) and burdened with 20 C.F.R. § 1.2(d), *see* note 3 *supra*—failed to persuade the Second Circuit that the DOWCP, not the Board, should be the proper federal respondent in § 921(c) proceedings. The court of appeals stated in dictum,

> Trying to make sense out of these regulations, we think that while the Director, OWCP is a proper party before the ALJ or the BRB . . . , the BRB is the proper agency respondent for review in the court of appeals . . . . We deem it best to defer resolution of this question to a case where decision on this point is essential; perhaps in the meanwhile the Department will tidy up its regulations.

Pittston Stevedoring Corp. v. Dellaventura, 544 F.2d 35, 43 n.5 (1976). It was in response to this suggestion that the

In so holding, we choose not to rely on Rule 15(a) as the Director urges us to do. In *McCord v. Benefits Review Board*, 514 F.2d 198 (D.C. Cir. 1975), this court granted the Board's unopposed motion to dismiss itself as a respondent in a section 921(c) review proceeding. The court stated that the rationale of Rule 15(a) does not apply to this type of proceeding.

> Normally, a single private party is contesting the action of an agency, which agency must appear and defend on the merits to insure the proper adversarial clash requisite to a "case or controversy." . . . Here, there is sufficient adversity between [the employer] and [the claimant] to insure proper litigation without participation by the Board. To require the Board to appear as a party would parallel requiring the District Court to appear and defend its decision upon direct appeal.

514 F.2d at 200. The court listed as another reason for dismissal a corollary of the first: the court could carry out its judgment and order without any further action required of the Board. *Id.* In this case, too, there is "sufficient adversity" between petitioner Shahady and the named respondents to ensure a "case or controversy." Rule 15(a) contemplates that the agency respondent defend the agen-

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Secretary promulgated 20 C.F.R. § 802.410(b). The Supreme Court, presented with the recently issued regulation, stated:

> The Court of Appeals questioned whether the [DOWCP], the federal respondent here, was a proper party in the Court of Appeals. . . . It concluded that some federal participation was proper and did not reach the question whether the BRB should have been substituted for the Director. . . . [N]either party has raised any question in this Court concerning the identity of the federal respondent. ***This question is therefore not before us.*** The Department of Labor has recently promulgated a regulation ***making it clear that the Director of OWCP is the proper federal party in a case of this nature.***

Northeast Marine Terminal Co. v. Caputo, 432 U.S. 249, 256 n.11 (1976) (emphasis added).

cy's (commission, or board) decision because the respondent *represents* the agency. In LHWCA cases, the Benefits Review Board—as a purely adjudicative entity—functions as a district court.[9] There is no *necessary* identity of interest between the BRB and DOWCP. The Director decides independently to support the Board's order, and if so, to what extent and in what manner.

The Director argues that if the Board is not a proper federal respondent, then the DOWCP must be. We disagree. The reasoning of *McCord*—that the rationale of Rule 15(a) is inapplicable to this kind of situation—applies as much to the DOWCP as it does the Board. We

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[9] Most other courts that have dismissed the Board as respondent have followed the reasoning of *McCord*. *See, e.g.*, DOWCP v. Eastern Coal Corp., 561 F.2d 632, 648-49 (6th Cir. 1977) ("Just as a District Court is not a necessary party in this court for review of its decision, we hold the Benefits Review Board is likewise not a necessary party to this litigation."); Nacirema Operating Co., Inc. v. Benefits Review Board, 538 F.2d 73, 75 (3d Cir. 1976) (Board now performs the function which prior to 1972 LHWCA amendments was performed by a district court; Board, like the district court, has no duty or interest in defending its actions on appeal); ITO Corp. of Baltimore v. Benefits Review Board, 529 F.2d 1080, 1089 (4th Cir. 1975) (sufficient adversity between employer and claimant; Board's participation unnecessary to ensure proper litigation), *dismissal of Board noted and left undisturbed upon rehearing en banc*, 542 F.2d 903, 907 n.4 (1976), *cert. denied*, 433 U.S. 908 (1977); Offshore Food Service and Aetna Cas. Surety Co. v. Benefits Review Board, 524 F.2d 967 ("Neither [§ 921(c) nor Rule 15(a)] requires the Board to be a party nor is its presence as a party necessary to effectuation of orders this court may enter.").

Only one circuit has relied on Rule 15(a) in holding the Board to be a proper respondent. Prolerized New England Co. v. Benefits Review Board, 637 F.2d 30, 40-41 (1st Cir. 1980). Notably, the DOWCP also participated in that case as party-respondent. The only other decision in conflict with the reasoning of *McCord* is *Pittston Stevedoring*, discussed *infra* at 13.

agree with Judge Friendly; we too "find it hard to believe that . . . Congress [in the 1972 LHWCA amendments] meant to oust the Government from participation as of right." *Pittston Stevedoring Corp. v. Dellaventura*, 544 F.2d 35, 43 n.5 (2d Cir. 1976), *aff'd sub nom. Northwest Marine Terminal Co. v. Caputo*, 432 U.S. 249 (1977). But we believe that the Act, not Rule 15(a), dictates our conclusion that *the Director* shall be named as federal party-respondent in section 921(c) proceedings.

III. Conclusion

We hold that the Director, OWCP shall be named as federal party-respondent in all petitions for review brought under section 21(c) of the LHWCA, 33 U.S.C. § 921(c), regardless of the level or degree of active participation of the Director before the Board. The Director may freely elect either to support the Board's decision and order, in whole or in part, to side with petitioner and urge reversal, or to refrain from taking a position. The Director's motion to amend and reform the caption in No. 81-1818 is therefore granted.

APPENDIX G

BENEFITS REVIEW BOARD
U.S. DEPARTMENT OF LABOR

No. 79-724

JAMES SHAHADY
Claimant-Petitioner

v.

ATLAS TILE & MARBLE

and

HARTFORD ACCIDENT & INDEMNITY COMPANY
Employer/Carrier
Respondents

FILED AS PART OF THE RECORD

JUN 11 1981
(date)

/s/
Clerk
Benefits Review Board

DECISION and ORDER

Appeal from the Decision and Order of Robert A. Briggs, Administrative Law Judge, United States Department of Labor.

Wayne M. Mansulla, (Ashcraft & Gerel), Washington, D.C., for the claimant.

William P. Dale, (McChesney & Pyne), Washington, D.C., for the employer/carrier.

Before: SMITH, Chief Administrative Appeals Judge, MILLER* and KALARIS, Administrative Appeals Judges.

*Separate opinion by MILLER, Administrative Appeals Judge, to follow.

KALARIS, Administrative Appeals Judge:

This is an appeal by claimant from the Decision and Order (79-DCWC-252) of Administrative Law Judge Robert A. Briggs pursuant to the provisions of the Longshoremen's and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901 *et seq.*, as extended by the District of Columbia Workmen's Compensation Act, 36 D.C. Code § 501 *et seq.* (hereinafter, the Act). Claimant appeals the administrative law judge's decision not to award to claimant payment for the medical services rendered by three physicians, Drs. Pecson, Schuster, and Edelson.

Claimant injured his left knee on November 19, 1975, while engaged in his employment as a marble mason. About one week after the injury, claimant came under the care of his family physician, Dr. Pecson. However, as claimant's knee worsened, claimant's employer, Atlas Tile and Marble (hereinafter, employer), referred claimant to Dr. Gibson, who thereafter performed surgery on claimant on April 2, 1977. Dr. Gibson continued to treat claimant until April 1978, when claimant and Dr. Gibson experienced some "unpleasantness." After this "unpleasantness," claimant once again sought treatment from Dr. Pecson. On advice of Dr. Pecson, claimant was operated on by Dr. Schuster.[1] Claimant continued to see both Drs. Pecson and Schuster after the operation.

The administrative law judge held that, even though Dr. Pecson was claimant's "initial free choice," employer was not liable for these medical expenses because claimant had not requested that employer authorize treatment by Dr. Pecson, as provided in Section 7(d) of the Act. 33 U.S.C.

[1]Dr. Edelson assisted Dr. Schuster in the operation on claimant.

§ 907(d). The administrative law judge denied claimant payment of the medical expenses of Drs. Schuster and Edelson because claimant had failed to obtain a written consent to change physicians as required by 20 C.F.R. § 702.406. The administrative law judge also found that none of the physicians had properly filed medical reports, as required by Section 7(d).

Claimant has advanced several arguments in his appeal of the administrative law judge's decision not to award payment of the medical expenses. However, review of both claimant's arguments on appeal and the Decision and Order of the administrative law judge reveals that there are three issues involved in this appeal: whether employer was absolved of its obligation to pay for medical services rendered to claimant because of claimant's failure to obtain prior authorization; whether certain alleged actions by employer's physician and insurance carrier constituted a refusal by employer to provide further medical care; and whether the administrative law judge properly refused to excuse the failure of the physicians who treated claimant to file the required medical reports.

We note initially that the Board's scope of review is limited. Therefore, where the findings and conclusions of the administrative law judge are supported by substantial evidence in the record considered as a whole, are not irrational, and are in accordance with law, they must be affirmed by the Board. 33 U.S.C. § 921(b)(3); *O'Keeffe v. Smith, Hinchman & Grylls Associates, Inc.*, 380 U.S. 359 (1965).

As a general rule, an employer is responsible for furnishing medical services and supplies that may be required as the result of a work-related injury. *See* 33 U.S.C. § 907(a). However, Section 7(d) conditions a claimant's

recovery of medical expenses on the occurrence of one of three events provided that the required physician's report is filed or failure to file is excused: the claimant requests that the employer furnish medical treatment and the employer refuses or neglects to do so; or the claimant requests that the employer authorize medical treatment by a physician chosen by the claimant and the employer refuses or neglects to do so; or the nature of the injury requires immediate medical treatment and the employer, having knowledge of the injury, neglects to provide or authorize treatment.[2] Where the employer refuses or neglects to provide medical treatment when requested, or refuses to authorize treatment upon request, and the claimant thereafter procures necessary medical treatment, the employer must bear these expenses. *See* 33 U.S.C. § 907(d).

The controversy in the instant case revolves around the payment for medical treatment provided by physicians

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[2]Employer's obligations in an emergency situation are further defined in 20 C.F.R. §§ 702.405 and 702.421. In his dissent in *Jackson v. Navy Exchange*, 9 BRBS 437, BRB No. 77-374 (1978), Administrative Appeals Judge Miller argued that an employer was liable for any medical treatment, including treatment that claimant did not request in advance, if this treatment was subsequently found necessary, the employer had knowledge of the injury, and the employer neglected to provide or to authorize such treatment. *Jackson*, 9 BRBS at 440. However, as indicated earlier, it is the majority's opinion that an employer's obligation to furnish medical treatment is conditioned upon claimant's requesting either treatment or authorization for treatment, except in the case of an emergency. In the instant case, the administrative law judge found, and substantial evidence in the record supports the finding, that no emergency situation existed. We, therefore, need only address the prior authorization requirements of Section 7(d) in this case. *O'Keefe, supra.*

chosen by claimant himself. We first address the issue of whether, under the facts of this case, claimant was required to request authorization from employer prior to obtaining medical treatment. Claimant argues that, as Dr. Pecson was his "initial free choise" pursuant to Section 17(b) of the Act and 20 C.F.R. § 702.406, there was no requirement that claimant obtain authorization prior to seeking Dr. Pecson's services. While the administrative law judge agreed that Dr. Pecson was claimant's "initial free choice," Judge Briggs nevertheless denied payment of these medical expenses since claimant had failed to obtain authorization prior to seeing Dr. Pecson. Citing decisions from the Courts of Appeals for the Fourth and Ninth Circuits, the administrative law judge held that Section 7(d) provides that a claimant is not entitled to recover payment for any medical expenses unless the claimant has first requested that employer "authorize provision of medical or surgical services by the physician selected by the employee and the employer shall have refused . . ." *See Maryland Shipbuilding and Dry Dock Co. v. Jenkins,* 549 F.2d 404, 10 BRBS 1 (4th Cir. 1979), *Nardella v. Campbell Machine, Inc.,* 525 F.2d 45, 3 BRBS 78 (9th Cir. 1975). *See generally Jackson v. Navy Exchange,* 9 BRBS 437, BRB No. 177-374 (1978).

We agree with the administrative law judge that claimant's entitlement to an initial free choice of a physician under Section 7(b) does not negate the requirement under Section 7(d) that claimant obtain employer's authorization prior to seeking recovery for the medical services of that physician. As it is clear from the facts of the instant case that none of the conditions of Section 7(d) had been met, we conclude that the administrative law judge's decision denying payment of Dr. Pecson's medical services because of claimant's failure to obtain authorization prior to see-

ing Dr. Pecson,[3] is supported by substantial evidence and is in accordance with law. *O'Keeffe, supra.*

We realize that our decision today is not in accord with the Board's earlier decision in *Bulone v. Universal Terminal & Stevedoring Corp.*, 8 BRBS 515, BRB No. 78-154 (1978). However, in *Bulone,* the applicability of Section 7(b) was erroneously considered without any reference to Section 7(d). Therefore, to the extent that *Bulone* is inconsistent with our determination in the instant case, *Bulone* is overruled.

As concerns the medical services of Dr. Schuster, claimant argues that they should be viewed as an extension of the services rendered by Dr. Pecson. Being under the impression that no prior authorization was required before seeking the services of Dr. Pecson, claimant's "initial free choice," claimant takes the position that no prior authorization was required before seeing Dr. Schuster either. We have held herein that, although Dr. Pecson was claimant's "initial free choice," claimant was nevertheless

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[3]It is obvious that Dr. Pecson was claimant's "initial free choice" after his injury. However, as to claimant's return to Dr. Pecson after the "unpleasantness" with Dr. Gibson, it is not certain whether Dr. Pecson remained claimant's "initial free choice" or whether this should be viewed as a "change of physicians." While under certain circumstances this difference in terminology could be significant, we believe that in the instant case it is unnecessary to address this difference for two reasons. First, regardless of whether these latter visists to Dr. Pecson are termed part of claimant's "initial free choice" or a "change of physicians," claimant was obligated to obtain some form of authorization from employer, which, in either event, claimant failed to do. Secondly, as an alternative reason, the administrative law judge denied payment of the medical services rendered by Dr. Pecson because Dr. Pecson failed to file the necessary medical reports. The failure to file these reports is sufficient by itself to support the denial of the payment.

obligated to obtain authorization prior to seeing Dr. Pecson. Thus, even if we view Dr. Schuster's services as an extension of Dr. Pecson's services, claimant failed to obtain the required authorization. Moreover, in *Nardella, supra,* the Ninth Circuit rejected claimant's argument that no additional authorization was required before receiving treatment from physicians to whom claimant had been referred by his "primary physician." *Nardella,* 3 BRBS at 82. Although *Nardella* was a pre-amendment case, we agree with the result reached therein and consider the rationale of that case equally applicable to the amended Section 7(d). Additionally, we agree with the administrative law judge that reimbursement for the services rendered by Drs. Schuster and Edelson should be disallowed since claimant failed to obtain a written consent to change physicians as required by 20 C.F.R. § 702.406. *And see* 33 U.S.C. § 907(b).

Claimant further argues that there are acts attributable to employer, each of which would constitute a refusal by employer to provide further medical care, and, thus, negate claimant's obligation to obtain authorization prior to seeking medical treatment. As earlier noted, if a claimant requests the employer to furnish medical treatment or services, or to authorize such treatment by a physician selected by claimant, the employer must bear the costs of such treatment. The Board, however, has concluded that, under certain circumstances, the actions of an employer can be tantamount to a refusal by the employer to either provide treatment or to authorize treatment. When the actions of an employer are such that they are tantamount to a refusal, the claimant is thereby entitled to payment or reimbursement for any subsequently obtained treatment. *See Rogers v. Pal Services,* 9 BRBS 807, BRB No. 77-636 (1978) (employer's physician's discharge of claimant, who

was nevertheless still disabled, held tantamount to a refusal by employer to provide further treatment); *Washington v. Cooper Stevedoring Co.*, 3 BRBS 474, BRB No. 75-237 (1976), *aff'd sub nom. Cooper Stevedoring of Louisiana v. Washington*, 556 F.2d 268, 6 BRBS 324 (5th Cir. 1977) (employer's physician's misdiagnosis held tantamount to a refusal to provide further medical treatment). *See also Mitchell v. Sun Shipbuilding & Dry Dock Co.*, 7 BRBS 215, BRB Nos. 77-1205 (3d Cir. Nov. 17, 1978).

In the instant case, claimant argues that the unpleasantness which occurred between Dr. Gibson and himself was tantamount to a refusal by employer to provide further medical care. However, there is a conflict in the testimony over the degree of this unpleasantness. The administrative law judge held that this unpleasantness did not constitute a refusal by employer to provide further medical care. Decision and Order at 4. Substantial evidence supports the administrative law judge's finding, and we therefore affirm.[4] *O'Keeffe, supra.*

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[4]Claimant also "tangentially" notes that Dr. Gibson "may be guilty of medical malpractice," citing *Washington v. Cooper, supra,* which held that a misdiagnosis was a refusal under the Act. Our examination of the record below reveals that claimant elicited evidence on the competency of Dr. Gibson's treatment of the purpose of establishing claimant's dissatisfaction with Dr. Gibson's treatment on the theory that under such circumstances claiamnt would not be required to continued under the care of Dr. Gibson. Hearing Transcript, pp. 90-91. We agree with employer that claimant's argument is irrelevant to the question of whether the proper statutory and regulatory procedures were satisfied in obtaining medical treatment. *Id.* Further, the phraseology of claimant's argument indicates that a finding of medical malpractice is not and cannot be seriously pressed on appeal, nor was the evidence below developed to that end. For these reasons we reject claimant's argument.

Claimant also contends that, in his visit to Dr. Gibson during which the unpleasantness occurred, claimant requested further treatment from Dr. Gibson, but was told that he had recovered from his injury and required no further treatment, thus constituting an effective refusal under the Act. The administrative law judge found that, with regard to Dr. Gibson, there was no refusal by employer to provide medical care. We have reviewed the record as a whole and find that there is substantial evidence to sustain the administrative law judge's conclusion. *See* Hearing Transcript, pp. 70-71, 78, 80; Cl. Ex. 6, Report of Dr. Gibson, April 14, 1978. We affirm. *O'Keeffe, supra.*

Finally, in his attempt to establish a refusal by employer to provide further medical care, claimant cites two occasions in which employer's insurance carrier refused to authorize medical services. Claimant argues that, on these occasions, when he was being admitted to Doctor's Hospital, the hospital telephoned employer's insurance carrier and inquired as to whether the carrier would authorize the scheduled treatment. On both occasions, the carrier refused to authorize the treatment. Claimant maintains that these two incidents constitute requests for authorization by employee and refusals by employer, thus satisfying the prior authorization requirement for the treatment requested and the requirement of a "refusal" by employer to provide further care.

We are, however, unable to accept this third argument advanced by claimant. The administrative law judge found that, with respect to the hospital admissions, there was no request by claimant to the employer or carrier for the prior furnishing of such services. Decision and Order at 3. We hold that there is substantial evidence in the record to sustain this finding. The only record evidence of these requests by the hospital personnel is claimant's bare

allegation that the telephone calls were made. Hearing Transcript, pp. 82, 86. Moreover, even assuming that the requests were made, there is no evidence that the telephone calls apprised employer or carrier that the hospitalization was for claimant's work-related injury to his left knee. As employer notes in its brief, claimant had a prior right knee injury and compensation case arising out of an injury that occurred in 1974 with another employer and carrier. Thus, there is not sufficient evidence of the contents of the two telephone calls made by Doctor's Hospital to show that the insurance carrier knew that it was being requested to authorize treatment for an injury for which it was responsible. Under these facts, the insurance carrier's refusal to authorize treatment should not now be the basis for finding the carrier liable. Accordingly, we affirm the administrative law judge's finding that the provisions of Section 7 were not complied with, and thus employer is not chargeable for the medical treatment that claimant subsequently obtained.

In addition to denying the claim for payment of the medical services because claimant had failed to obtain the required prior authorization, the administrative law judge also denied the claim because none of the physicians complied with Section 7(d) in regard to the filing of the required medical reports. Section 702.422(a), 20 C.F.R. § 702.422(a), premises an employer's liability for payment of medical services on the receipt by employer and the deputy commissioner of a medical report from the attending physician within 10 days following the date of the first treatment. In the instant case, the evidence discloses that Drs. Pecson and Edelson never filed the medical reports required by Section 7(d) and, although Dr. Schuster did file an Attending Physician's Report with the deputy commissioner, this report was filed three months

after the initial treatment and surgery. Under the provisions of Section 702.422(b), 20 C.F.R. § 702.422(b), the Secretary of Labor has delegated to the administrative law judge the authority to excuse the failure to file the required medical reports within 10 days.

The arguments raised by claimant in his attempt to establish that employer acted in a manner that was tantamount to a refusal to provide further medical treatment are also asserted as reasons to excuse the failure of the physicians to properly file the required reports. However, we have already considered these arguments and determined that the administrative law judge did not abuse his discretion in finding that none of the acts cited by claimant constituted a refusal by employer to provide or authorize medical treatment. Therefore, the rationale of *Buckhaults v. Shippers Stevedoring Company*, 2 BRBS 277, BRB No. 75-132 (1975) (employer's refusal of further medical care held to negate the finding that failure to file the required medical report was unjustified) is inapposite. Accordingly, we affirm the administrative law judge's finding that there is ". . . no basis for excusing the failure of the respective attending physicians to properly submit the report(s) required by the statute." Decision and Order, slip op. at 4. This noncompliance mandates a denial of the request for payment of the medical services.

Lastly, claimant argues that the Section 20 presumption applies to the issue of the filing of the medical reports required by Section 7(d). Claimant maintains that compliance with Section 7(d) must be presumed unless and until employer fulfills its burden of proving noncompliance with the Act. Claimant also argues that, since employer did not raise the issue of the "timeliness" of Dr. Schuster's reports before the administrative law judge, it was improper for the administrative law judge to raise this issue

on his own.[5] Moreover, claimant argues that, since employer failed to raise the "untimeliness" defense before the administrative law judge, employer cannot raise this issue for the first time on appeal.

First, it has been held that the filing of the medical reports as required by Section 7(d) is not included within the Section 20 presumption. *Maryland Shipbuilding and Dry Dock Co. v. Jenkins, supra* at 407. Secondly, in his opening statement counsel for employer specifically brought to the court's attention the regulation concerning the "effect of failure to report on medical care after initial authorization." Hearing Transcript at 34. Further, on October 22, 1979, three days after the hearing, claimant was directed by the administrative law judge to file any attending physician's reports or reports of initial treatment and any letter or other request made to employer/carrier to provide medical treatment or services. ALJ Ex. 1. Claimant's reply to this request was a reference to the reports of Dr. Pecson. Cl. Ex. 14. However, counsel for employer responded to this request by indicating that Employer's Exhibit 4 was an Attending Physician's Report of Dr. Schuster and noted that this report had been dated three months after the first treatment. Emp. Ex. 11.

Under these circumstances, we hold that the issue of compliance with Section 7 in regard to the medical reports was properly before the administrative law judge and all parties had a sufficient opportunity to address this issue.

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[5]In making this argument, claimant only refers to Dr. Schuster's failure to submit the required reports within 10 days as required by the Act. Claimant offers no explanation as to why this argument was not extended to include Dr. Pecson's and Dr. Edelson's failure to comply with Section 7. We will address this argument as if it applied to all three physicians.

Accordingly, we affirm the decision of the administrative law judge denying claimant's claim for payment of the medical services rendered by Drs. Pecson, Schuster and Edelson.

SO ORDERED.

/s/
ISMENE M. KALARIS
Administrative Appeals Judge

I Concur:

/s/
SAMUEL J. SMITH, Chief
Administrative Appeals Judge

APPENDIX H

BENEFITS REVIEW BOARD

U.S. DEPARTMENT OF LABOR

No. 79-724

JAMES SHAHADY
Claimant-Petitioner

v.

ATLAS TILE & MARBLE

and

HARTFORD ACCIDENT AND INDEMNITY COMPANY
Employer/Carrier-Respondents

FILED AS PART OF THE RECORD
SEP 21 1981
(date)
Agnes Kurtzman/KW
Clerk
Benefits Review Board

SEPARATE OPINION

MILLER, Administrative Appeals Judge, dissenting:

I must object to my colleagues' denial of claimant's request for the payment of medical services rendered by Drs. Pecson, Schuster, and Edelson. Preliminarily, I would find employer liable pursuant to Section 7(b) and 20 C.F.R. § 702.406 for the costs of treatment supplied by Dr. Pecson.

As the administrative law judge noted, Dr. Pecson was claimant's initial choice of physician. This fact alone should establish employer's responsibility for the fees associated with Dr. Pecson's treatment, since "claimant is entitled to an initial free choice of a physician with no need

of authorization. . . ." *Bulone v. Universal Terminal & Stevedoring Corp.*, 8 BRBS 515, 517 BRB No. 78-154 (1978)l. Howver, my colleagues, offering no rationale therefor, have determined that their *Bulone* decision is erroneous and that the Act mandates authorization prior to seeking treatment from the physician of claimant's initial free choice. In doing so, the majority disregards the judicial doctrine of *stare decisis*, the foundation of which, as noted in my dissenting opinion in *Clites v. Jones & Laughlin Steel Corp.*, 2 BLR 1-1019, BRB No. 79-358 BLA (1980), "is to insure that parties can place great reliance on the past decisions of an adjudicator as indicative of future decisions in a similar case. . . ." 2 BLR at 1-1028. Claimant has demonstrated his reliance on *Bulone*. *See* claimants Memorandum of Points and Authorities at 10. Accordingly, "[w]hen rights have been created. . .in reliance on established rules of law, the arguments against their change have specific force." *Thomas v. Washington Gas Light co.*, 12 BRBS 828, 835, 100 S.Ct. 2647 (1980) (plurality opinion). My colleagues have profferred no arguments to support a reversal of *Bulone*. Thus, I would find *Bulone* controlling and would hold employer liable for the cost of Dr. Pecson's services.

Additionally, I would find employer liable pursuant to Section 7(d) for the expenses incurred by claimant in treatment from all three physicians. For the reasons stated in my dissent in *Jackson v. Navy Exchange Service Center*, 9 BRBS 437, 440 BRB No. 77-374 (1978), I would hold that a claimant is not obliged to request authorization when the nature of his injury requires treatment, and employer has knowledge of the injury and neglects to provide care. In the instant case, the facts establish that the employer did not meet this burden.

Finally, I cannot subscribe to my colleagues' holding

that the timeliness issue of the physicians' reports "was properly before the administrative law judge. . . ." Majority Opinion, slip op. at 13. I am unable to assent to the majority's proposition that a bare allusion to a regulation constitutes the raising of a defense. On appeal, the employer attempts to excuse its failure to raise this issue below by maintaining that the administrative law judge "requested only brief references to the applicable statute and regulations in opening statements." Employer's Response Brief at 13. An examination of the record discloses no such request. Moreover, I hardly consider the opening statement of employer's counsel, consisting of ten transcript pages, as brief references to the statute and regulations.

I further object to the majority's premise that the employer's response to the administrative law judge's request for physicians' reports constitutes the raising of the untimeliness of said reports. In this letter, the employer does note that Dr. Schuster's report is dated three months subsequent to the date of the initial Treatment. However, the employer makes no mention of the physicians' reports of Drs. Pecson and Edelson. It is thus impossible for me to view this letter as an objection to the untimeliness of the reports of Drs. Pecson and Edelson.

I would further apply the Section 20(a) presumption to the issue of the timeliness of the physicians' reports. *See Jenkins v. Maryland Shipbuilding & Dry Dock Co.*, 6 BRBS 550, BRB No. 76-376 (1977), *rev'd*, 10 BRBS 1, 594 F.2d 404 (4th Cir. 1979). The employer had full opportunity at the hearing to establish the untimeliness of these reports. The employer failed to rebut the presumption by declining to present any evidence on this issue. The majority's approval of the administrative law judge's treatment of this issue is contrary to the interests of justice.

> Our mandate under the Act is to apply the terms of the [Act] in a principled fashion, striving to avoid 'harsh and incongruous results' whenever appropriate in light of the language and intent of the Act. . . . We must 'not construe the Act so as to enable [employers] to escape liability to persons entitled to recover for an admittedly compensable death by reading into it technical restrictions on the tolling of the filing period which are inconsistent with the purposes of the Act.'

Smith v. Aerojet-General Shipyards, Inc., 13 BRBS 391, 396, 647 F.2d 518 (5th Cir. 1981) *rev'g and remanding* 9 BRBS 225, BRB Nos. 76-346/A (1978) (Miller, dissenting) (citations omitted). *See also* my dissent in *Peterson v. Washington Metropolitan Area Transit Authority*, BRBS , BRB, No. 78-610 (June 11, 1981).

For the reasons stated herein, I would reverse the administrative law judge's denial of claimant's claim for medical expenses.

Julius Miller
Administrative Appeals Judge

Dated this 21st
day of September 1981

SERVICE SHEET

BRB No. 79-724: James R. Shahady v. Atlas Tile and Marble and Hartford Accident & Indemnity Company
(Case No. 79-DCWC-252) (OWCP No. 40-102454)

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APPENDIX I

In the Matter of	:	
JAMES SHAHADY	:	
Claimant	:	
v.	:	Case No. 79-DCWC-252
ATLAS TILE & MARBLE	:	
	:	OMCP No.
Employer	:	102454
HARTFORD ACCIDENT & INDEMNITY CO.	:	
Carrier	:	

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Before: ROBERT A. BRIGGS
Administrative Law Judge

DECISION AND ORDER

Pursuant to the provisions of the Longshoremen's and Harbor Workers' Compensation Act, as amended, 33 U.S.C. 901 *et seq.*, and the District of Columbia Workmen's Compensation Act, as amended, 36 D.C. Code 501 *et seq.*, a formal hearing was held before the undersigned in this proceeding. Transcript pages are referenced by the letter "T". The Employer/Carrier is hereinafter referred to as Respondent. All evidence and testimony has been carefully considered but to summarize herein would serve no useful purpose. Pursuant to directive (ALJ Ex.1), the parties have filed post-hearing submissions relating to attending physician's reports and any requests for medical care, which are received in evidence as Claimant Ex. 14 and Employer Ex. 11.

Based upon the entire record herein, including the stipulations of fact by the parties and evidence adduced, and from my observation of the witnesses and their demeanor, I make the following findings of fact, conclusions of law, and order.

Both parties are subject to the Act and in compliance with applicable notice are filing requirements of Sections 12 and 13. On November 19, 1975 claimant tripped and fell, striking his left knee, with said injury arising out of and in the course of his employment as a marble mason, which work requires considerable kneeling (T. 59). Two days later, he was treated and released to return to work by the NE Industrial Clinic (Claimant Ex. 4). Although he continued to work, his left knee condition worsened, and *October 8, 1976* his employer referred him to Dr. Gibson, an orthopedic surgeon. Conservative treatment proved unsuccessful, and surgery was performed by Dr. Gibson on April 2, 1977. Claimant continued to see Dr. Gibson until

April 14, 1978 (Claimant Ex. 6). Compensation payments for temporary total disability were made from April 1 to May 30, 1977 (Claimant Ex. 12). Claimant is presently receiving compensation which is not in issue at this time (T. 4). Claimant returned to work in early June 1977 (initially as a truck driver and, on October 3, 1977, returned to his regular work) and continued to work without missing any time through at least April 14, 1978 (Claimant Ex. 6).

Preceding, during, and subsequent to the above medical care of Dr. Gibson, claimant was also treated by his family physician, Dr. Pecson, commencing about one week after the injury (Claimant Ex. 2 at p. 1) and continuing at least through April 1979 (Employer Ex. 8). Claimant's condition further deteriorated and on *June 23, 1978,* Dr. Pecson advised claimant's attorney that claimant was "barely able" to work and *would be hospitalized on June 25 for corrective surgery* (Claimant Ex. 5.). Claimant was admitted to Doctor's Hospital on that date and referred to Dr. Schuster, an orthopedic surgeon, who *operated* on claimant's left knee four days later on *June 29, 1978.* (Claimant Ex. 2 at p. 1, 2). A bill for $200 by Dr. Edelstein who assisted Dr. Schuster at the operation is also claimed-Claimant Ex. 8. Subsequent to the above surgery, claimant continued to see both Dr. Pecson and Dr. Schuster. In November 1978, Dr. Schuster admitted claimant to Doctor's Hospital (a period of 4 days) for non-surgical treatment of his left knee (T. 57).

Claimant had no problems with his *left* knee prior to November 1975 but has since experienced pain, swelling and stiffness which have required two operations. I conclude that both operations were necessary and causally related (directly or indirectly) to claimant's injury of November 1975. Aggravation of a pre-existing condition is

compensable and, in this respect, there is no conflict in the evidence. I credit the opinion of Dr. Gibson that "The degenerative arthritis which pre-existed . . . suffered some aggravation both by the patient's injury and surgery . . ." (Claimant Ex. 6; T. 78.). Dr. Schuster's opinion further corroborates the above (Claimant Ex. 9). Accordingly, I find claimant's injury (and any sequelae thereof-such as may have resulted from subsequent necessary surgery by Dr. Gibson and Dr. Schuster) to be compensable. Thus, any *future* medical expenses (medication to relieve pain, orthopedic braces, future surgery, if necessary) would be recoverable *provided* there is compliance with Section 7 of the Act.

Past medical expenses. In March 1976 (about 4 months after his injury and over two years prior to treatment and surgery by Dr. Schuster), claimant retained the services of counsel who filed the instant claim on March 31, 1976 (Claimant Ex. 13). The parties have stipulated that neither claimant or his counsel contacted the insurance carrier to request medical treatment (T. 89). With respect to *all* of the treatments by Dr. Pecson, Dr. Schuster and Dr. Edelstein and related hospital admissions, there has been no request by claimant to the employer or carrier for the *prior* furnishing of such services (also Claimant Ex. 14). In this respect, I find that an emergency situation did not exist herein (as noted, supra, claimant's attorney was advised nearly a week prior to surgery on June 29 - Claimant Ex. 5) but rather a slowly deteriorating condition over a period of nearly 3 years, culminating in claimant's operation on June 29, 1978. Although there was some unpleasantness between claimant and Dr. Gibson, I find that this does not constitute a refusal by the employer to provide further medical treatment, particularly in view of claimant's statutory right to a physician of his choosing. In this

respect, I find that claimant did not select Dr. Gibson, but that Dr. Pecson was his initial choice. As no request was made (and there was no emergency or refusal by employer), the claim herein for past medical expenses must be denied.

Athough claimant is entitled to an initial free choice of physician, Section 7(d) provides that he is not entitled to recover any medical expenses unless he has requested that employer "authorize provision of medical or surgical services *by the physician selected by the employee* and the employer shall have refused . . ." (emphasis added). Decisions of the 4th and 5th Circuit Court of Appeals in *Nardella* v. *Campbell Machine,* 525 F.2d 45, 3 BRBS 78 (1975) and *Maryland Shipbuilding v. Jenkins,* 549 F.2d 404, 10 BRBS 1 (1979) are dispositive. Also compare *Jackson v. Navy Exchange,* 9 BRBS 437, 439 (1978).

Although failure to request authorization requires denial, the claim is *additionally* denied because neither Dr. Pecson nor Dr. Edelstein have filed *the reports required by Section 7(d).* An Attending Physician's report filed with the Deputy Commissioner (but not the employer) by Dr. Schuster on September 25, 11978 (Employer Ex. 4 at p. 3) some *three months subsequent to initial treatment and surgery* does not comply with Section 7(d). Under the circumstances of this case, and considering claimant's representation by counsel since March 1976, I find no basis for excusing the failure of the respective attending physicians to properly submit the report(s) required by statute. CF. *Maryland Shipbuilding,* supra, 10 BRBS at p. 8. As Dr. Pecson was claimant's initial choice, subsequent medical services by Dr. Schuster and Dr. Edelstein are denied for the *additional* reason that written consent to change physicians was not obtained as required by 20 CFR 702.406.

As noted in *Nardella* and *Maryland Shipbuilding*, supra, although the Longshore Act is to be interpreted liberally, the plain terms of the statute may not be disregarded under the guise of liberal interpretation. Section 7(b) and implementing regulation at 20 CFR 702.407 *et seq. require* that the Deputy Commissioner *shall* actively supervise the medical care rendered to injured employees, including making determinations with respect to the necessity of medical care furnished or to be furnished, determinations with respect to change of physicians, the appointment (where appropriate) of impartial specialists to assist in resolving medical disputes based on differing medical evaluations, and the requiring of periodic reports as to the medical care being rendered. 20 CFR 702.422 provides that the employer/carrier is not liable even for authorized medical care unless the treating physician shall furnish, within 10 days of his first treatment, a report to the employer *and* to the Deputy Commissioner (failure to furnish such report may be excused when in the interest of justice to do so).

In the instant case, comprehensive procedures for the providing of appropriate medical care, supervised and monitored by the Deputy Commissioner, and for the resolution of any disputes concerning such care were thwarted by claimant's failure to apprise either the employer *or* the Deputy Commissioner of his decision to seek additional medical aid (also T. 38). As in *Maryland Shipbuilding*, supra, such failure is further exacerbated by the fact that claimant obtained legal advice shortly after the injury (and continuing) some two years prior to the initial treatment and surgery by Dr. Schuster. In the instant case, counsel for claimant has tried hundreds of cases under the Longshore Act, is knowledgeable as to its requirements, and had represented claimant in a prior com-

pensation claim (T. 88). Although claimant may obtain such medical care as he wishes without request or notification to anyone, such expenses are not chargeable to his employer under the Longshore Act unless the provisions of Section 7 are complied with.

Should medical treatment or surgery be deemed necessary in the future, claimant (or his counsel) is advised to forward a written request to the employer/carrier with a copy to the Deputy Commissioner. A written request for any future change of physician should be made to the Deputy Commissioner or, alternatively, to the employer.

ORDER

For the above reasons, the claim herein for medical expenses of Dr. Pecson, Dr. Schuster, Dr. Edelstein and any related hospital expenses is denied.

/s/

ROBERT A. BRIGGS
Administrative Law Judge

APPENDIX J

BENEFITS REVIEW BOARD
U.S. DEPARTMENT OF LABOR

No. 80-515

MARK W. LLOYD	)
Claimant-Petitioner	)
	)
v.	)
	)
SLATTERY ASSOCIATION, INC.	)
and	)
HARTFORD ACCIDENT AND INDEMINITY COMPANY	)
Employer/Carrier-Respondents	)

FILED AS PART OF THE RECORD
SEP 30 1982
Agnes Kurtz
Clerk
Benefits Review Board

DECISION and ORDER

Appeal from the Decision and Order of Robert J. Brissenden, Administrative Law Judge, United States Department of Labor.

Timothy F. X. Cleary (Ashcraft & Gerel), Washington, D.C., for the claimant.

William P. Dale (McChesney & Pyne), Washington, D.C., for the employer/carrier.

Before: RAMSEY, Chief Administrative Appeals Judge, MILLER and KALARIS, Administrative Appeals Judges.

MILLER, Administrative Appeals Judge:

This is an appeal by claimant from the Decision and Order (77-DCWC-11) of Administrative Law Judge Robert J. Brissenden pursuant to the provisions of the Longshoremen's and Harbor Worker's Compensation Act, as amended, 33 U.S.C. § 901 *et seq.*, as extended by the District of Columbia Workmen's Compensation Act, 36 D.C. Code § 501 *et seq.* (hereinafter, the Act).

Claimant suffered a work-related back injury on October 30, 1975. In a Decision and Order dated April 1, 1977, claimant was awarded compensation and medical benefits under the Act. On April 5, 1978, the parties entered into a lump sum settlement of the compensation benefits. The settlement provided for future medical treatment related to claimant's injury.

Shortly after the injury, claimant consulted Dr. Hyde at the employer's clinic. Claimant was later referred to Dr. Gordon by Dr. Hyde. There is no dispute as to the claimant's right to be treated by either of these doctors. However, claimant became dissatisfied with Dr. Gordon's care and began undergoing treatment by Dr. Schuster on August 22, 1979.[1]

The administrative law judge found that claimant had not requested that employer authorize the treatment by Dr. Schuster as required by Section 7(d) of the Act. 33 U.S.C. § 907(d). The administrative law judge also found that Dr. Schuster failed to file a medical report within 10 days following the first treatment as required by Section 7(d). Accordingly, he denied the claim for medical expenses in regard to treatment by Dr. Schuster.

---

[1]Additionally, the claimant visited Dr. Rida Azer on three occasions. There is also no dispute with respect to the right to consult this doctor.

Claimant contends that he is entitled to reimbursement for medical expenses because the employer effectively refused to provide medical treatment. Claimant further argues that, once the employer has refused medical treatment, it is not within the spirit of the Act to deny reimbursement for necessary medical expenses simply because claimant did not request further treatment. Finally, claimant argues that, based on *Buckhaults v. Shippers Stevedore Co.*, 2 BRBS 277 (1975), employer's refusal to authorize medical care negates the administrative law judge's finding that there was no justification for Dr. Schuster's failure to timely file his medical report.

Employer initially contends that the administrative law judge correctly determined that employer did not refuse to provide medical care. Moreover, employer argues that, even if Dr. Gordon had refused to provide further treatment, it should not be liable since Dr. Gordon was not the employer's doctor. Lastly, employer maintains that claimant has not shown good cause for Dr. Schuster's failure to timely file a medical report.

The Board must affirm a decision if the findings of the administrative law judge are supported by substantial evidence in the record considered as a whole, if they are rational, and if the decision is in accordance with law. *O'Keeffe v. Smith, Hinchman & Grylls Associates, Inc.*, 380 U.S. 359 (1965); 33 U.S.C. § 921(b)(3).

As a general rule, an employer is responsible for furnishing medical services and supplies that may be required as the result of a work-related injury. *See* 33 U.S.C. § 907(a). Nevertheless, Section 7(d) provides in pertinent part as follows:

> An employee shall not be entitled to recover any amount expended by him for medical or other

> treatment or services unless he shall have requested the employer to furnish such treatment or services, or to authorize provision of medical or surgical services by the physician selected by the employee, and the employer shall hvae refused or neglectd to do so, or unless the nature of the injury required such treatment and services and the employer or his superintendent or foreman having knowledge of such injury shall have neglected to provide or authorize the same; nor shall any claim for medical or surgical treatment be valid and enforceable, as against such employer, unless within ten days following the first treatment the physician giving such treatment furnish to the employer and the Secretary a report of such injury and treatment, on a form prescribed by the Secretary. The Secretary may, however, excuse the failure to furnish such report within ten days when he finds it to be in the interest of justice to do so, and he may, upon application by a party in interest, make an award for the reasonable value of such medical or surgical treatment so obtained by the employee.

Claimant does not contend that he requested authorization to consult Dr. Schuster or that he requested further treatment from Dr. Gordon. However, he argues that the actions of Dr. Gordon are sufficient to constitute a refusal of treatment. Case law establishes that, under certain circumstances, the actions of an employer's physician can be tantamount to a refusal by the employer to etiher provide treatment or to authorize treatment, thus obviating the need for claimant to request either treatment or authorization of treatment. When the actions of an employer are such that they are tantamount to a refusal, the claimant is thereby entitled to payment or reimbursement for any subsequently obtained necessary treatment. *See Altantic &*

Gulf Stevedores, Inc. v. Neuman, 440 F.2d 908 (5th Cir. 1971); *Rogers v. Pal Services,* 9 BRBS 807 (1978); *Walker v. AAF Exchange Service, 5 BRBS 500 (1977); Washington v. Cooper Stevedoring Co.,* 3 BRBS 474 (1976), *aff'd sub nom. Cooper Stevedoring of Louisiana, Inc. v. Washington,* 556 F.2d 268, 6 BRBS 324 (5th Cir. 1977); *Buckhaults.* In *Washington,* the Board held that a mistaken diagnosis was equivalent to a refusal of treatment. 3 BRBS at 479.

In the instant case, Dr. Gordon and Dr. Schuster did not actually diagnose claimant's ailments differently. Each found back pain complicated by accompanying emotional problems. Their disagreement was with respect to the proper method of treatment. Nevertheless, we conclude that Dr. Gordon's actions are tantamount to a mistaken diagnosis, because the administrative law judge explicitly found that Dr. Schuster's treatment was reasonable and necessary and that his approach differed considerably from Dr. Gordon's. Thus, we find that claimant was refused treatment and incurred expenses for further necessary medical treatment. Claimant can recover the cost of this further treatment if the refusal of treatment is attributed to the employer. *See Shahady v. Atlas Tile & Marble Co.,* ____ F.2d ____, No. 81-1818 (D.C. Cir. June 4, 1982), *rev'g* 13 BRBS 1007 (1981) (Miller, J., dissenting); *Rogers, supra.*

In this case, the administrative law judge concluded that "[t]here was no evidence to indicate that Dr. Gordon was employer's representative." However, the record indicates that claimant was referred to Dr. Gordon by Dr. Hyde, the physician at the employer's clinic. Moreover, Dr. Gordon was called by employer as its witness. Therefore, we determine that the administrative law judge's conclusion that Dr. Gordon was not employer's representative is irra-

tional. Accordingly, we hold that Dr. Gordon's Refusal of treatment by virtue of misdiagnosis must be attributed to employer.

Finally, we must address claimant's contention that the refusal of treatment negates the administrative law judge's finding that there was no justification for Dr. Schuster's failure to timely file his medical report. In *Shahady*, the United States Court of Appeals for the District of Columbia Circuit held that, when an employer refuses to provide medical care, an administrative law judge's refusal to excuse a physician's failure to timely file his medical reports as required by Section 7(d) is an abuse of discretion. Accordingly, we hold that the administrative law judge abused his discretion by not excusing Dr. Schuster's failure to timely file his medical report.

For the foregoing reasons, the Decision and Order of the administrative law judge is reversed, and the case is remanded or an award of benefits.

SO ORDERED,

/s/ Julius Miller
Administrative Appeals Judge

I concur:

Robert L. Ramsey, Chief
Administrative Appeals Judge

KALARIS, Administrative Appeals Judge, concurring:

I am of the opinion that the decision of the District of Columbia Court of Appeals in *Shahady v. Atlas Tile Marble Co.*, ____ F.2d____, No. 81-1818 (D.C. Cir. June 4, 1982), *rev'g* 13 BRBS 1007 (1981), requires reversal of the administrative law judge's denial of medical costs in the case before us. *Shahady* controls the results herein because this claim, too, arises in the District of Columbia Circuit. I therefore concur in the result reached by my colleagues, However, I continue to disagree with the circuit court's opinion in *Shahady,* and herewith set forth my disagreement in the context of the case now before the Board.

The administrative law judge below determined that employer could not be deemed to have refused to provide claimant with treatment (which refusal would have eliminated the claimant's duty under Section 7(d) to request the services of another physician, Dr. Schuster) because of the actions of Dr. Gordon, employer's physician.[1] The administrative law judge below evaluated Dr. Gordon's actions in the light of *Walker v. AAF Exchange Service,* 5 BRBS 500 (1977), which held that, where an employer's physician makes a determination may be tantamount to a refusal by employer to provide care thus eliminating any duty on the part of the employee under Section 7(d) to request medical care. *See also Atlantic & Gulf Stevedores, Inc. v. Neuman,* 440 F.2d 908 (5th Cir. 1971). The administrative law judge found that, since Dr. Gordon's report and testimony were to the effect that,

[1]I fully concur in my colleagues' conclusion that Dr. Gordon is employer's physician on the facts of this case.

since Dr. Gordon's report and testimony were to the effect that emotional problems remained, Dr. Gordon did not deem claimant fully recovered; therefore claimant's duty to request that employer provide additional care would remain intact under the *Walker* rationale. In my view, the administrative law judge's conclusions on this point are supported by substantial evidence in the record and may not, therefore, be disturbed on appeal. *O'Keeffe v. Smith, Hinchman & Grylls Associates, Inc.*, 380 U.S. 359 (1965); *Cardillo v. Liberty Mutual Insurance Co.*, 330 U.S. 469 (1947).

The administrative law judge went on to conclude that an employee's simple dissatisfaction with the treatment and his disagreement on the state sof recovery, even if communicated to employer's doctor, would not be enough to constitute a request to employer for medical care. However, the opinion of the court in *Shahady*, appears to require a contrary result. In *Shahady*, an employer's physician had stopped treatment of the claimant (despite lack of recovery), which action the court equated with a "discharge" from treatment; the result was that the claimant's after-acquired medical care, since necessary and related to the industrial injury, was reimbursable by the employer. I see little to distinguish the case before us from the facts in *Shahady*. In the case before us, Dr. Gordon withheld the kind of treatment that Dr. Schuster later provided because Dr. Gordon did not believe that such treatment was necessary. The claimant, by Dr. Gordon's own admission, had nevertheless not recovered. As in *Shahady*, the administrative law judge below found that the treatment provided by Dr. Schuster was both reasonable and necessary. On these facts, I believe that the District of Columbia Circuit would, under *Shahady*, find an effective "discharge" in Dr. Gordon's actions, and, therefore,

would find an effective refusal on the part of employer to provide further medical treatment.[2]

In my view, a finding that Dr. Gordon's actions constitute a "discharge" from treatment is a legal fiction that obscures the reality of the case. I agree with the administrative law judge's characterization of the legal issue before us which is, simply, whether the requirements of Section 7(d) are met where an employee, who is dissatisfied with treatment or who disagrees with the state of his recovery, secures other medical treatment without request of the employer and that treatment is ultimately found to be necessary, and causally related to his employment injury. The plain language of section 7(d) requires an answer in the negative. The request must be made, followed by employer's refusal to provide care, unless the nature of the injury requires immediate medical treatment, that is, unless an emergency situation exists. *See Jackson v. Navy Exchange*, 9 BRBS 437 (1978); 20 C.F.R. §§ 702.405 and 702.421. Since no emergency situation existed in the case before us, the employee was required by statute to request treatment or authorization for treatment from employer. Failure to comply bars the employee's recovery of medical expenses by the plain language of Section 7(d). 33 U.S.C. § 907(d). It has often been said that, where "Congress has put down its pen, [the Court] can neither rewrite Congress' words nor call it back 'to cancel half a line.' " *Director, OWCP v. Rasmussen*, 440 U.S. 29, 47 (1979). For this reason, the Board is not empowered to create judicial exceptions to the prior authorization requirements of Sec-

[2]My colleagues achieve a similar result by finding that Dr. Gordon's actions constitute a "mistaken diagnosis," and, therefore, an effective refusal on the part of employer to provide further medical treatment. I cannot ascribe to this finding because Dr. Gordon did not diagnose claimant's ailments differently than Dr. Schuster.

tion 7(d) for the employee who is dissatisfied with his treatment and secures necessary treatment elsewhere.

With regard to the issue of the failure of Dr. Schuster to timely file the physician's report required by Section 7(d), I concur in the result reached by my colleagues because *Shahady* is controlling. My colleagues are correct that the D.C. Circuit held in *Shahady* that, when an employer refuses to provide necessary medical care, an administrative law judge's refusal to excuse the physician's failure to file his Section 7(d) report, where medical services are otherwise reimbursable, is an abuse of discretion. *Shahady*, slip op. at 4. Accordingly, the administrative law judge's refusal to excuse Dr. Schuster's failure to timely file his report is reversible error as a matter of law in the D.C. Circuit on the facts of this case. However, the D.C. Circuit's opinion on this issue is based on a mistaken premise.

The court stated in *Shahady* that its holding, that it is an abuse of discretion for the administrative law judge to refuse to excuse the failure to timely file the physician's report in the situation where the employer refuses to provide care, is compelled by the Board's own precedent in *Buckhaults v. Shippers Stevedore Co.*, 2 BRS 277 (1975). I do not agree. *Buckhaults* involved a situation where the administrative law judge refused to excuse the physician's failure to file his report because the administrative law judge believed that employer had not refused medical care. Since the Board held as a matter of law that the employer had indeed refused to provide medical care, the Board remanded in *Buckhaults* for the administrative law judge to reconsider excusing the failure to file the doctor's report in light of employer's refusal to provide care. *Buckhaults* does not hold, as the court in *Shahady* would say, that the administrative law judge must as a matter of

law excuse the failure to file the Section 7(d) report where employer has refused to provide treatment. Indeed, *Buckhaults* properly remanded the case for the administrative law judge to reconsider his conclusion, since the statute provides for excusing the failure to timely file the physician's report when it is "in the interest of justice to do so." 33 U.S.C. § 907(d); *and see* n20 C.F.R. § 702.422. Finding the Section 7(d) filing requirement excused is a discretionary act under the plain language of the statute and is not made mandatory by the single fact that employer has refused to provide medical care. For example, an administrative law judge may be confronted with a situation where a physician treated claimant's disease over a long period of time but never filed the report despite his knowledge that the illness was occupational in origin. Perhaps the physician was paid from other sources and the claimant may have had legal counsel during the period of treatment. Such facts would require a judgment as to whether it is in the interests of justice to excuse the failure to file, and that judgment is not pre-ordained, under Board law or under a fair reading of the statute, where the single factor of employer's refusal to provide care is present. Assuming, therefore, that there has been a refusal by employer in the case before us, Board law would require remand for reconsideration of the issue of excusing the physician's failure to timely file his Seciton 7(d) report. Because *Shahady* mandates reversal in the D.C. Circuit, however, I concur in the judgment of my colleagues.

ISMENE M. KALARIS
Administrative Appeals Judge

Dated this 30th day of September 1982

SERVICE SHEET

BRB No. 80-15: Mark W. Lloyd v. Slattery Association, Inc. and Hartford Accident and Insurance Co.
(Case No. 77-OWCP No. 4-99153)

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No. 82-654

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

ATLAS TILE & MARBLE COMPANY and
HARTFORD ACCIDENT & INDEMNITY COMPANY,
Petitioners,

v.

JAMES R. SHAHADY

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION
PROGRAMS, U.S. DEPARTMENT OF LABOR,
Respondents.

PRIVATE PARTY RESPONDENT'S BRIEF IN OPPOSITION TO A PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

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QUESTIONS PRESENTED

I. IN A CASE ARISING UNDER THE LONGSHOREMEN'S AND HARBOR WORKERS' COMPENSATION ACT, IF A PHYSICIAN SELECTED BY AN INSURANCE CARRIER DISCHARGES A CLAIMANT AND THAT CLAIMANT THEN PROCURES NECESSARY MEDICAL TREATMENT, SHOULD THE INSURANCE CARRIER BE HELD LIABLE FOR THE COSTS OF THAT NECESSARY TREATMENT DESPITE THE CLAIMANT'S FAILURE TO FORMALLY REQUEST A CHANGE OF PHYSICIANS?

II. IN SUCH A CIRCUMSTANCE, IS THE TERMINATION OF ACTIVE MEDICAL TREATMENT AND DISCHARGE BY THE PHYSICIAN TO WHOM CLAIMANT IS REFERRED BY THE EMPLOYER DEEMED TO CONSTITUTE A REFUSAL OR NEGLECT BY THE EMPLOYER TO PROVIDE OR AUTHORIZE MEDICAL CARE OR TREATMENT UNDER THE ACT?

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JURISDICTION

The Court of Appeals for the District of Columbia Circuit had jurisdiction under 33 U.S.C. § 921(c) (1976 Ed.). The judgment of the Court of Appeals was entered on June 4, 1982 and petitioner's motion for rehearing was denied on July 16, 1982. The petition for certiorari was filed within 90 days of the latter date. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

United States Code, Title 33:

§ 907. Medical services and supplies.

(a) The employer shall furnish such medical, surgical, and other attendance or treatment, nurse and hospital service, medicine, crutches, and apparatus, for such period as the nature of the injury or the process of recovery may require.

(b) The employee shall have the right to choose an attending physician authorized by the Secretary to provide medical care under this Act as hereinafter provided. If, due to the nature of the injury, the employee is unable to select his physician and the nature of the injury requires immediate medical treatment and care, the employer shall select a physician for him. The Secretary shall actively supervise the medical care rendered to injured employees, shall require periodic reports as to the medical care being rendered to injured employees, shall have authority to determine the necessity, character, and sufficiency of any medical aid furnished or to be furnished, and may, on his own initiative or at the request of the employer, order a change of physicians, or hospitals when in his judgment such change is desirable or necessary in the interest of the employee. Change of physicians at the request of employees shall be permitted in accordance with regulations of the Secretary.

(c) The Secretary may designate the physicians who are authorized to render medical care under the Act. The names of physicians so designated in the community shall be made available to employees through posting or in such other forms as the Secretary may prescribe.

(d) An employee shall not be entitled to recover any amount expended by him for medical or other treatment or services unless he shall have requested the employer to furnish such treatment or services, or to authorize provision of medical or surgical services by the physician selected by the employee, and the employer shall have refused or neglected to do so, or unless the nature of the injury required such treatment and services and the employer or his superintendent or foreman having knowledge of such injury shall have neglected to provide or authorize the same; nor shall any claim for medical or surgical treatment be valid and enforceable, as aginst such employer unless within ten days following the first treatment the physician giving such treatment be valid and enforceable, as against Secretary a report of such injury and treatment, on a form prescribed by the Secretary. The Secretary may, however, excuse the failure to furnish such report within ten days when he finds it to be in the interest of justice to do so, and he may upon application by a party in interest, make an award for the reasonable value of such medical or surgical treatment so obtained by the employee. If at any time the employee unreasonably refuses to submit to medical or surgical treatment, or to an examination by a physician selected by the employer, the Secretary may, by order, suspend the payment of further compensation during such time as such refusal continues, and no compensation shall be paid at any time during the period of such suspension, unless the circumstances justified the refusal.

(e) In the event that medical questions are raised in any case, the Secretary shall have the power to cause the employee to be examined by a

physician employed or selected by the Secretary and to obtain from such physician a report containing his estimate of the employee's physical impairment and such other information as may be appropriate. Any party who is dissatisfied with such report may request a review or reexamination of the employee by one or more different physicians employed or selected by the Secretary. The Secretary shall order such review or reexamination unless he finds that it is clearly unwarranted. Such review or reexamination shall be completed within two weeks from the date ordered unless the Secretary finds that because of extraordinary circumstances a longer period is required. The Secretary shall have the power in his discretion to charge the cost of examination or review under this subsection to the employer, if he is a self-insurer, or to the insurance company which is carrying the risk, in appropriate cases, or to the special fund in section 44.

(f) An employee shall submit to a physical examination under subsection (e) at such place as the Secretary may require. The place, or places [sic] shall be designated by the Secretary and shall be reasonably convenient for the employee. No physician selected by the employer, carrier, or employee shall be present at or participate in any manner in such examination, nor shall conclusions of such physicians as to the nature or extent of impairment or the cause of impairment be available to the examining physician unless otherwise ordered, for good cause, by the Secretary. Such employer or carrier shall, upon request, be entitled to have the employee examined immediately thereafter and upon the same premises by a qualified physician or physicians in the presence of such physician as the employee

may select, if any. Proceedings shall be suspended and no compensation shall be payable for period during which the employee may refuse to submit to examination.

Code of Federal Regulations. Title 20:

§ 702.403. Employee's right to choose physician; limitations.

The employee shall have the right to choose his attending physician from among those authorized by the Director, OWCP, to furnish such care and treatment. In determining the choice of a physician, consideration must be given to availability, the employee's condition and the method and means of transportation. Generally 25 miles from the place of injury, or the employee's home is a reasonable distance to travel, but other pertinent factors must also be taken into consideration.

§ 702.406 Change of physicians; non-emergencies.

Whenever the employee has made his initial, free choice of an attending physician, he may not thereafter change physicians without the prior written consent of the employer (or carrier) or the deputy commissioner. Such consent shall be given in cases where an employee's initial choice was not of a specialist whose services are necessary for, and appropriate to, the proper care and treatment of the compensable injury or disease. In all other cases, consent may be given upon a showing of good cause for change.

§ 702.407 Supervision of medical care.

The Director, OWCP, through the deputy commissioners and their designees, shall actively

supervise the medical care of an injured employee covered by the Act. Such supervision shall include:

(a) The requirement that periodic reports on the medical care being rendered be filed in the office of the deputy commissioner, the frequency thereof being determined by order of the deputy commissioner or sound judgment of the attending physician as the nature of the injury may dictate;

(b) The determination of the necessity, character and sufficiency of any medical care furnished or to be furnished the employee;

(c) The determination of whether a change of physicians, hospitals or other persons or locales providing treatment should be made or is necessary;

(d) The further evaluation of medical questions arising in any case under the Act, with respect to the nature and extent of the covered injury, and the medical care required therefor.

§ 702.418 Procedure for requesting medical care; employee's duty to notify employer.

As soon as practicable, but within 30 days after occurrence of an injury covered by the Act, or within 30 days after an employee becomes aware, or in the exercise of reasonable diligence should be aware, of the relationship between an injury or disease and his employment, the injured employee or someone on his behalf shall give written notice thereof to the deputy commissioner having jurisdiction over the place where the injury occurred and to the employer. If a form has been prescribed for such purpose it shall be used, if available and practicable under

the circumstances. Notices filed under Subpart B of this part, if on the form prescribed by the Director for such purpose, satisfy the written notice requirements of this subpart.

§ 702.419 Action by employer upon acquiring knowledge or being given notice of injury.

Whenever an employer acquires knowledge of an employee's injury, through receipt of a written notice or otherwise, said employer shall forthwith authorize, in writing, appropriate medical care. If a form is prescribed for this purpose it shall be used whenever practicable.

§ 702.420 Issuance of authorization; binding effect upon insurance carrier.

The issuance of an authorization for treatment by the employer shall bind his insurance carrier to furnish and pay for such care and services.

§ 702.421 Effect of failure to obtain initial authorization.

An employee shall not be entitled to recover for medical services and supplies unless he shall have first requested authorization from his employer therefor. This prohibition shall not apply in emergency situations, nor shall it apply in cases where the employer (including the superintendent, foreman, or other person having charge of the work and having knowledge of the injury) refuses or neglects to authorize such care when requested by the employee.

§ 702.422 Effect of failure to report on medical care after initial authorization.

(a) Notwithstanding that medical care is properly obtained in accordance with these regulations, the employer and his insurance carrier

shall not be liable for the expense thereof unless the physician rendering such initial care or services furnishes a report thereof to the employer and to the deputy commissioner having jurisdiction. The report required by this section shall be furnished within 10 days following the date of first treatment. The report shall be upon a form prescribed by the Director for such purpose.

(b) For good cause shown, the deputy commissioner or administrative law judge may excuse the failure to file the report within 10 days, and further, may make an award for the reasonable value of such medical care.

STATEMENT OF THE CASE

On November 19, 1975, private party respondent, James R. Shahady,[1] was employed by the Atlas Tile & Marble Company, petitioner herein. At that time, the employer's insurance carrier was the Hartford Accident and Indemnity Co., also a petitioner herein.

On that day, respondent was injured when he jumped from an eighteen inch high platform, struck a pipe protruding from an unfinished floor, fell and landed on his left knee. The impact cut the knee, but not to such an extent that Mr. Shahady felt it necessary to seek medical attention. However, the next day, respondent went to the Northeast Industrial Clinic, where the staff gave Mr. Shahady a tetanus shot and pain pills and x-rayed the knee. He was told he could return to work.

Mr. Shahady returned to work, but by January 1976, the pain and swelling forced him to seek the aid of Dr.

[1]Mr. Shahady will be referred to as "respondent" or Mr. Shahady.

Bernard Pecson, his family physician.[2] Dr. Pecson sent respondent to Doctors Hospital in Prince Georges County for an arthrogram. The arthrogram showed that a baker's cyst had developed and that both the lateral and medial minisci (cartilage) were torn. Dr. Pecson felt that the tears were not severe enough to operate and Mr. Shahady returned to work. Respondent returned with further complaints of pain and swelling on August 4, 1976 and again on August 16, 1976, at which time Mr. Shahady was informed that surgery of the left knee might be indicated.

The Hartford Accident and Indemnity Company, petitioner herein, requested, however, that respondent see Dr. Marvin M. Gibson, an orthopedic surgeon.[3] Mr. Shahady complied, first visiting Dr. Gibson on October 8, 1976. Dr. Gibson diagnosed tears of the lateral and medial menisci, relaxation of the medial collateral ligament and a baker's cyst, all of the left knee. However, the doctor treated Mr. Shahady conservatively. In compliance with Dr. Gibson's requests, respondent returned for visits in November 1976 and January 1977. Dr. Gibson recommended that respondent continue to work, that he continue to exercise his knee and advised him to consider an arthrotomy if he became unable to work. Finally, Mr. Shahady was admitted to Doctors Hospital by Dr. Gibson on April 1, 1977 because he was unable to work. Respondent underwent surgery on April 2, 1977. Dr. Gibson reported having removed the popliteal fasci (baker's cyst) and the medial and lateral menisci of the left knee. Although Dr. Gibson had noted during surgery that the

[2]The administrative law judge found Dr. Pecson to be respondent's "initial free choice." (App. p. 48A).

[3]Respondent notes that there is nothing in the record to support petitioner's statement that respondent was sent to Dr. Gibson "because Dr. Pecson did not submit a medical report pursuant to 33 U.S.C. § 907(c)." (Petition, p. 6).

collateral ligament was loose, he did not surgically correct it. Dr. Gibson followed Mr. Shahady's recovery from April 1977 to April 1978, during which time Dr. Gibson allowed respondent to work.

By April 1978, Mr. Shahady's knee worsened to the point where he was unable to bend down or get up while working. The knee was locking and giving way. Respondent saw Dr. Gibson for the last time on April 14, 1978, and again related the problems he was experiencing. During that visit, respondent and Dr. Gibson had a disagreement. Dr. Gibson asked respondent when "he had received his medical degree" and told respondent that there was nothing wrong with his leg.[4]

Petitioner again sought the aid of Dr. Pecson, who sent Mr. Shahady to Doctors Hospital for a second arthrogram, which again showed a ruptured medial meniscus and a baker's cyst. The second arthrogram was virtually identical to the first; it showed the same knee ailments for which Dr. Gibson had allegedly performed corrective surgery. On June 25, 1978, Dr. Pecson admitted Mr. Shahady to Doctors Hospital and, being unable to perform surgery, referred him to a board-certified orthopedic specialist, Dr. Gerald D. Schuster.

Upon entering Doctors Hospital, Mr. Shahady informed the admissions personnel that Hartford Accident and Indemnity Company was the responsible carrier. In accordance with normal procedure, the hospital called Hartford to inquire into petitioner's coverage. The petitioner denied responsibility.

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[4]It was this incident which the Court of Appeals held to be a refusal under "judicial and BRB precedent." *Shahady v. Atlas Tile and Marble Co.*, 682 F.2d 968, 970 (D.C. Cir 1982) (App. 9a).

Dr. Schuster diagnosed a marked internal derangement of the left knee requiring immediate surgery. On June 29, 1978, Dr. Schuster operated on Mr. Shahady's knee. He repaired the loose medial collateral ligament and the anterior cruciate ligament which Dr. Gibson had failed to do during the first operation. He excised the torn portion of the medial meniscus which Dr. Gibson had allegedly removed during the first operation, and also removed bone spurs.[5] Respondent remained in the hospital for seventeen days.

Dr. Schuster continued to follow Mr. Shahady's recovery. Unfortunately, by November 6, 1978, respondent had lost mobility in his left knee, and was admitted to Doctors Hospital for closed knee manipulation. Mr. Shahady responded well and was discharged on November 11, 1978. Prior to admitting respondent, Doctors Hospital again called Hartford to check on coverage and the employer's carrier again denied that it would assume expenses for Mr. Shahady's further medical treatment. Mr. Shahady remained in the hospital with all attendant costs for an additional four days. Since November 1978, Mr. Shahady has continued to have problems with his knee. It continues to swell, has lost strength and has had to be drained. At the time of the administrative hearing, Mr. Shahady had not returned to work.

Respondent filed a claim for benefits under the Longshoremen's and Harbor Workers' Act, as amended, 33 U.S.C. § 901 *et seq.* (1976) as extended to cover employees under the District of Columbia Workers' Compensation Act, D.C. Code § 36-501 *et seq,* seeking payment for the medical expenses of Drs. Pecson, Schuster and Edelson, Dr. Schuster's assistant.

[5]Subsequently, respondent brought a malpractice action against Dr. Gibson, *Shahady v. Gibson*, C.A. No. 4461-80 (Super. Ct. D.C.).

OPINIONS AND DECISIONS BELOW

A formal hearing was held on October 19, 1979 before an Administrative Law Judge who denied the claim for reimbursement for medical expenses. The Opinion is contained in Appendix I, p. 44a.

On appeal, the Benefits Review Board, one member dissenting, affirmed the decision of the Administrative Law Judge. In so doing, the Board overruled its prior holding in *Bulone v. Universal Terminal & Stevedoring Corp.*, 8 BRBS 515, BRB No. 78-154 (1978), which held that a claimant was entitled to reimbursement for medical expenses incurred from treatment rendered by his "initial free choice" of treating physician, 33 U.S.C. § 907(b), even if there had been no prior request by the claimant to his employer. The opinion of the Board, dated June 11, 1981, appears as Appendix H. p. 38a.

Respondent then filed a petition for review in the United States Court of Appeals for the District of Columbia Circuit pursuant to 33 U.S.C. § 921(c). The Director of the Office of Workers' Compensation Programs of the United States Department of Labor, who was not named as an agency respondent in claimant's petition, moved to amend and reform the caption to be included as a respondent (although aligning himself with Mr. Shahady). The caption of the case was reformed in accordance with a decision of the United States Court of Appeals. *Shahady v. Atlas Tile & Marble Company,* 673 F.2d 479 (D.C. Cir. 1982) (Appendix F., p. 12a)

Respondent raised five issues before the Court of Appeals. The Federal respondent addressed two of those issues on behalf of Mr. Shahady's behalf.

On June 4, 1982, the Court of Appeals reversed the Benefits Review Board and the Administrative Law Judge

and held the employer and carrier responsible for the medical bills in question. The Court of Appeals held that the actions by Dr. Gibson constituted a refusal by the petitioner to provide medical treatment, and that all subsequent necessary treatment procured by respondent is reimbursable, citing *Atlantic & Gulf Stevedores, Inc. v. Neuman*, 440 F.2d 908, 911 (5th Cir. 1971). *Buckhaults v. Shippers Stevedore Co.*, 2 BRBS 277, BRB No. 75-132 (1975); *Walker v. AAF Exchange Service*, 5 BRBS 500, BRB No. 76-185 (1977); and *Kilson v. Sun Shipbuilding & Dry Dock Co.*, 2 BRBS 172, BRB No. 75-127 (1975).

The Court of Appeals also held that Drs. Pecson's, Schuster's and Edelson's failure to file timely reports should have been excused, citing *Buckhaults, supra* at 280, and that the failure to do so was an abuse of discretion.

The Court did not reach the question whether, in the absence of a refusal attributable to the employer to provide necessary medical treatment, the Act would have required respondent to request his employer's authorization for the medical services in question.[6] That decision, dated June 4, 1982 appears as Appendix E, p. 7a.

Petitioners filed a timely Petition for Rehearing and Petition for Rehearing *en banc* with the Court of Appeals. On July 16, 1982, the Petitions for Rehearing were denied by the Court of Appeals without opinion. (Appendix B., p. 3a, Appendix C, p. 5a).

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[6]Petitioner's statement that the Court of Appeals "ignored" respondent's failure to comply with aplicable provisions for changing treating physicians, (Petition p. 8.), is curious. The entire thrust of the decision was that such a failure is excused when the carrier is responsible for inadequate medical treatment. This finding is consistent with both the "humanitarian purpose of the Act." *Leyden v. Capitol Reclamation*, 2 BRBS 24 (1975) *aff'd mem.* 547 F.2d 706 (D.C. Cir. 1977) and the doctrine of equitable estoppel.

SUMMARY OF ARGUMENT

The petition for *certiorari* should not be granted because the Court of Appeals merely applied a long standing, settled and narrow doctrine: Where the employer's physician refuses to provide adequate medical treatment, the employee must be reimbursed for all subsequent, necessary treatment he procures, regardless of his failure to comply with the requirements of 33 U.S.C. § 907(d) and the regulations promulgated thereunder. See 20 C.F.R. § 702.418 *et seq.* Similarly, that the employer's doctor's actions can be imputed to the employer is a well established principle under prior judicial and administrative decisions. The refusal by an employer, through his physician, to provide necessary medical treatment was properly held to excuse the failure of the respondent's doctors to file medical reports. Such a finding is wholly consistent with the requirement of 33 U.S.C. § 907(d) that such a waiver be "in the interest of justice", and with the requirement of 20 C.F.R. § 702.422 that such a waiver be granted "good cause shown".

REASONS FOR DENYING THE WRIT

I. THE COURT OF APPEALS MERELY APPLIED LONG ESTABLISHED PRECEDENT WHICH HOLDS THAT AN EMPLOYER/CARRIER MAY NOT REFUSE TO PAY FOR NECESSARY MEDICAL TREATMENT PROCURED BY AN EMPLOYEE WHERE THAT CARRIER'S DOCTOR HAD REFUSED TO PROVIDE TREATMENT.

Throughout its petition, petitioner has overstated the breadth of the Court of Appeals' ruling. The Court of Appeals holding only applies when 1) the employer/carrier sends an employee to a doctor of its own choosing; 2) that doctor wrongfully refuses to provide treatment; 3) the employee then procures necessary treatment related to the injury; 4) without first seeking approval for the change of physicians.[7] Only under these circumstances is an employer responsible for unauthorized medical treatment.

Contrary to what the petitioner states, more is needed than to have the "claimant disagree" (Petition, p. 10) with the doctor for this exception to apply. Excusing a failure to request a change of physicians is consistent with the "humanitarian purpose of the Act", *Wheatley v. Adler*, 407 F.2d 307, 314 (D.C. Cir. 1968)) (en banc), as well as common sense. If the employer's physician has said that no further treatment is necessary, it will certainly oppose a change of physicians in accordance with Section 7(b) of

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[7]Petitioner's statement that the "only difference of opinion [between Drs. Gibson and Schuster] was therefore one of medical judgment" (Petition, p. 10, fn2) is clearly erroneous. During the second operation, Dr. Schuster removed the same medical meniscus that Dr. Gibson had claimed to have removed, and repaired a ligament which Dr. Gibson had left alone.

the Act, 33 U.S.C. § 907(b). Thus, such a request would be a futile, time consuming and unproductive gesture.

Petitioner's statement that the Court of Appeals decision will result in "prejudice to the employer and carrier" (Petition, p. 10) again ignores the narrow scope of the decision. Again, under the administrative and judicial precedent relied on by the Court of Appeals, the employer is only liable for necessary treatment procured by an employee after the physician selected by the employer/carrier wrongfully refuses to provide treatment. Thus, the employee is not given "free reign to go anywhere he chooses," (Petition, p. 10) but is narrowly constrained in his actions.[8]

Thus, the Court of Appeals merely applied existing law. In reversing the agency, the Court noted that "the BRB failed to act in accordance with basic tenets of administrative law: by reaching an unsupported determination without distinguishing its own precedent." 682 F.2d at 970, (App. 10a). Given the narrow scope of this holding, and the application of well established precedent, this Court should decline this opportunity to review the decision of the U.S. Court of Appeals for the District of Columbia Circuit. Furthermore, petitioner's statement that "the Court of Appeals' designation of Dr. Gibson as 'employer's physician' and its attribution to the employer of Dr. Gibson's conduct find no basis in the law of agency and ignores the independent nature of Dr. Gibson's practice" (Petition, p. 14, fn3) is contrary to law. Section 14N

[8]In addition to being necessary, all charges must be consistent with prevailing charges in the medical community. 20 C.F.R. § 702.413.

of the Restatement, Second, of Agency provides that "one who contracts to act on behalf of another and subject to the other's control except with respect to his physical conduct is an agent and also an independent contractor."

II. PETITIONER HAS FAILED TO RAISE AN IMPORTANT QUESTION OF FEDERAL LAW.

Petitioner's second argument is that an important question of federal law has been raised; yet it fails to cite a single case which conflicts with the decision below. There is only one explanation for this failure – neither the Benefits Review Board nor any Court of Appeals has seen fit to reject the doctrine laid down in *Atlantic and Gulf Stevedores v. Neuman,* 440 F.2d 908 (5th Cir. 1971). Moreover, the cases cited by petitioner (Petition, pp. 18-19) are not distinguishable, but actually support respondent's argument.

Maryland Shipbuilding and Dry Dock Co. v. Jenkins, 594 F.2d 404, 10 BRBS 1 (4th Cir. 1979) involved a claimant who was injured, treated and released from treatment, but whose employer had not refused to provide treatment. When his condition worsened, claimant sought the advice of his *lawyer* who referred claimant to a doctor. Furthermore, he refused to submit to an examination by a "company" doctor in whom he lacked confidence. *Jenkins, supra,* at 405. Claimant was denied treatment because of his refusal to submit to an exam, as well as his failure to seek authorization. Thus, *Jenkins* did not fit into any previously established exceptions to the filing requirements, as respondent did in the instant action. Also, as the *Jenkins* court noted, the equities of the case were in the employer's favor.

Nardella v., Campbell Machine, 525 F.2d 46 (9th Cir. 1975) is also distinguishable. *Nardella* involved a pre-amendment case where the Court held that the claimant, who had not been refused treatment, could not recover the cost of medical expenses where no medical reports had been filed and where those expenses were incurred after the claimant had recovered from his illness.

Jackson v. Navy Exchange, 9 BRBS 437, BRB No. 77-373 (1978), involved a situation where the *employee's* doctor allegedly misdiagnosed the claimant's condition. The claimant then saw numerous other doctors without authorization. The Board distinguished the facts of that case from situations where the claimant's condition was misdiagnosed by a doctor supplied by the employer. *Jackson, supra* at 439. There can be no doubt that the respondent's final visit to the employer's physician constituted a request for treatment under *Jackson.* Thus, *Jackson* actually supports the Court of Appeals holding in the instant action as well as respondent's position.

Similarly, petitioner's attack on the Court of Appeals' reliance on *Atlantic & Gulf Stevedoring v. Neuman,* 440 F.2d 908 (5th Cir. 1971) is myopic. What petitioner has failed to point out is that the *Neuman* opinion has been adopted by the Benefits Review Board on many occasions when dealing with post-amendment cases. See *Buckhaults v. Shippers Stevedore Co.,* 2 BRBS 277, BRB No. 75-132 (1975); *Walker v. AAF Exchange Service,* 5 BRBS 500, BRB No. 76-185 (1977); and *Kilson v. Sun Shipbuilding & Dry Dock Co.,* 2 BRBS 172, BRB No. 75-127 (1975).

Petitioner also wrongfully assumes that the mere amendment of an Act is to be used to justify the outright rejection of prior judicial decision, absent any evidence of

congressional intent. Respondent respectfully submits that the petitioner has applied the wrong test to measuring congressional knowledge of judicial decisions. As the Court said in *Cannon v. University of Chicago,* 441 U.S. 677, 696-7 (1979), "It is *always* appropriate to assume that our elected representatives, like other citizens, know the law . . ." (emphasis added). This rule of law, in various forms, has been followed by courts nationwide. "In searching for the will and intent, it is to be assumed that Congress was aware of established rules of law applicable to subject matter of the statute and thus, upon enactment the statute is to be read in conjunction with the entire existing body of law." *Kansas City, Mo. v. Federal Pacific Electric Co.,* 310 F.2d 271, 275 (8th Cir. 1962) *cert. denied* 371 U.S. 912 (1963), *cert. denied* 373 U.S. 914 (1963), 50 Am. Jur. Statutes § 339; *Exploration Company v. United States,* 247 U.S. 435, 449 (1918). "It is a settled rule of statutory construction that a legislature is presumed to act with knowledge of existing law on the subject, and absent a clear manifestation of contrary intent, its enactments are presumed to be harmonious with that existing body of law. " *Finberg v. Sullivan,* 461 F.Supp. 253, 258 (E.D. Pa. 1978). Respondent respectfully submits that this is the correct rule of law to be applied in the case at bar.

Moreover, petitioner's suggestion that the inclusion of a claimant's right to select his initial treating physician remedied all the evils present under pre-amendment law is absurd, as the instant case demonstrates. The 1972 amendments did not address, in any way, what would happen if the employer's physician *refused* to provide treatment. The suggestion that Congress intended to abrogate the *Neuman* decision is without foundation. Therefore, the petition for *certiorari* should be denied.

III. THE COURT OF APPEALS DECISION BELOW MERELY APPLIED A RULE OF LAW ESTABLISHED BY THE ADMINISTRATIVE AGENCY WHEN IT EXCUSED THE RESPONDENT'S DOCTOR'S FAILURE TO PROVIDE MEDICAL REPORTS.

Petitioner's third argument, like its first two, both overstates the breadth of the Court of Appeals holding and fails to recognize the well established principles on which it rests. The Court of Appeals held that the failure of respondent's doctors to file medical reports should have been excused under Section 7(d), 33 U.S.C. § 907(d), as it was "in the interest of justice to do so." 33 U.S.C. § 907(d), *Buckhaults v. Shipper's Stevedore Company*, 2 BRBS 277, BRB No. 75-132 (1975).

It is true that in *Buckhaults* the Board remanded the case to the administrative law judge. However, that case was ". . . remanded to determine whether such a report was filed and if not, whether it is excusable in light of the employer's refusal of further medical care. . .",after the Board found "that the Administrative Law Judge's failure to recognize that the claimant was "refused" further medical treatment negates the finding that there was no justification for the failure to report" *Buckhaults, supra* at 280. Thus, the Board held that the employer's refusal to provide of further medical care precluded a finding that the failure to file the required medical report was unjustified. *See also Shahady v. Atlas Tile and Marble Co.*, 13 BRBS 1007, 1014 App. 35.[9] Again, the Court of Appeals

[9]Requiring filing of the medical reports after a refusal would not aid the employer or deputy commissioner. To expect a claimant to have reports sent to the employer by an unauthorized physician would place an unreasonable burden on the claimant.

did not establish new law, it merely followed the established precedents of the agency itself. Furthermore, there was no need to remand this case for further fact-finding as in *Buckhaults*. With the full record before it, the Court was free to reverse. *Hilyer v. Morrision-Knudsen*, 670 F.2d 208, 214 (D.C. Cir. 1981) *cert. granted* ____ U.S. ____ (October 3, 1982).

CONCLUSION

Given the narrow holding of the Court of Appeals, and its firm foundation in prior administrative and judicial precedent, this Honorable Court should deny the petition for *certiorari*.

Respectfully submitted

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No. 82-654

In the Supreme Court of the United States

OCTOBER TERM, 1982

ATLAS TILE & MARBLE COMPANY, ET AL., PETITIONERS

v.

JAMES R. SHAHADY, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION

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QUESTION PRESENTED

Whether an employee may be reimbursed under Section 7 of the Longshoremen's and Harbor Workers' Compensation Act, 33 U.S.C. 907, for necessary medical services causally related to a compensable injury, which were obtained by the employee after he had been discharged from further treatment against his objections by a physician selected by his employer.

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BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 7a-11a) is reported at 682 F.2d 968. The opinion of the Benefits Review Board (Pet. App. 25a-43a) is reported at 13 Ben. Rev. Bd. Serv. (MB) 1007. The decision of the administrative law judge (Pet. App. 44a-50a) is not reported.

JURISDICTION

The judgment of the court of appeals was entered on June 4, 1982. A petition for rehearing was denied on July 16, 1982 (Pet. App. 3a-5a). The petition for a writ of certiorari was filed on October 14, 1982. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. On November 11, 1975, respondent James Shahady, a marble mason employed by petitioner Atlas Tile & Marble Company, injured his left knee while on the job (Pet. App.

26a, 45a). Although Shahady returned to work two days later, his condition grew progressively worse. Approximately one week after injuring himself, Shahady consulted his family physician, Dr. Pecson (*id.* at 26a, 46a). At Atlas's request, on October 8, 1976, Shahady consulted Dr. Gibson, an orthopedic surgeon, who subsequently performed surgery (*id.* at 26a, 45a-46a).

In April 1978, at an "unpleasant" meeting in which Shahady requested further treatment, Dr. Gibson discharged Shahady from his care, telling Shahady he " 'was fine,' [and] 'there was nothing wrong with [his] leg' " (Pet. App. 9a). Shahady, who continued to experience difficulties with his knee, returned to Dr. Pecson, who referred him to an orthopedic surgeon, Dr. Schuster. Dr. Schuster and another surgeon, Dr. Edelson, operated on Shahady on June 29, 1978 (*id.* at 26a, 46a). Dr. Schuster also hospitalized Shahady for non-surgical treatment of his knee in November 1978 (*id.* at 46a).

2. Shahady applied for payment under the Longshoremen's and Harbor Workers' Compensation Act (LHWCA), 33 U.S.C. (& Supp. V) 901 *et seq.* (as extended to cover employees under the District of Columbia Workmen's Compensation Act, D.C. Code Ann. § 36-501, 36-502 (1973)[1]), for the medical services rendered by Drs. Pecson, Schuster, and Edelson. Although concluding that the treatment provided by Drs. Pecson, Schuster, and Edelson was "necessary" and "causally related" to Shahady's injury, the administrative law judge ("ALJ") denied Shahady's

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[1]The District of Columbia has since enacted a new workers' compensation statute. D.C. Code Ann. § 36-301 *et seq.* (1981). See *District of Columbia* v. *Greater Washington Central Labor Council*, 442 A.2d 110 (1982), petitions for cert. pending, Nos. 82-116 and 82-146 (filed July 20 and 26, 1982). Under the new local Act, District of Columbia workers who are not otherwise subject to the coverage provisions of the LHWCA are no longer within the LHWCA's scope.

claim (Pet. App. 10a, 46a-47a). The ALJ found that Dr. Gibson had not refused to provide Shahady further medical treatment, and that Shahady's failure to request Atlas to authorize treatment by Dr. Pecson therefore barred his claim under Section 7(d) of the LHWCA, 33 U.S.C. 907(d).[2] The ALJ also concluded that Shahady had failed to obtain a prior written consent to change physicians (see 20 C.F.R. 702.406) as to Drs. Schuster and Edelson, and that Drs. Pecson, Schuster, and Edelson had not filed timely medical reports pursuant to Section 7(d) of the LHWCA, 33 U.S.C. 907(d) (Pet. App. 26a-27a, 47a-49a).[3]

3. The Benefits Review Board, by a divided vote, affirmed the ALJ's decision. The Board overturned an earlier decision[4] and held that Shahady was required to obtain

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[2]Section 7(d), 33 U.S.C. 907(d), provides in pertinent part:

> An employee shall not be entitled to recover any amount expended by him for medical or other treatment or services unless he shall have requested the employer to furnish such treatment or services, or to authorize provision of medical or surgical services by the physician selected by the employee, and the employer shall have refused or neglected to do so * * *.

[3]The relevant portion of Section 7(d), 33 U.S.C. 907(d) provides:

> [N]or shall any claim for medical or surgical treatment be valid and enforceable, as against such employer, unless within ten days following the first treatment the physician giving such treatment furnish to the employer and the Secretary a report of such injury and treatment, on a form prescribed by the Secretary. The Secretary may, however, excuse the failure to furnish such report within ten days when he finds it to be in the interest of justice to do so, and he may, upon application by a party in interest, make an award for the reasonable value of such medical or surgical treatment so obtained by the employee.

See also 20 C.F.R. 702.422(b) ("For good cause shown, the deputy commissioner or administrative law judge may excuse the failure to file the report within 10 days, and further, may make an award for the reasonable value of such medical care.").

[4]*Bulone* v. *Universal Terminal & Stevedoring Corp.*, 8 Ben. Rev. Bd. Serv. (MB) 515 (1978).

authorization under Section 7(d) prior to consulting with Dr. Pecson, even though Dr. Pecson was Shahady's "initial free choice" under Section 7(b) of the Act, 33 U.S.C. 907(b) (Pet. App. 29a-30a). The Board concluded that Shahady was also obligated to obtain a separate authorization for Dr. Schuster (*id.* at 30a-31a), and that, in any event, Shahady should have obtained a written consent to change physicians (20 C.F.R. 702.406; see 33 U.S.C. 907(b)) before consulting with Drs. Schuster and Edelson (Pet. App. 31a).

The Board also rejected Shahady's contention that his failure to obtain authorization for the services of Drs. Pecson, Schuster, and Edelson was excused by his employer's failure to provide medical care (Pet. App. 31a-33a). The Board recognized that "[w]hen the actions of an employer are such that they are tantamount to a refusal [of further treatment], the claimant is thereby entitled to * * * reimbusement of any subsequently obtained treatment" without prior authorization (*id.* at 31a). The Board held, however, that substantial evidence supported the ALJ's finding that Dr. Gibson's discharge of Shahady from further treatment had not been a refusal of further medical care (*id.* at 32a-33a).

Finally, the Board asserted that all three physicians' failure to file medical reports required under Section 7(d) would have barred Shahady's claim even if the proper authorizations and written consents to change physicians had been obtained (Pet. App. 34a).

4. Shahady sought review of the Board's ruling in the court of appeals.[5] The court reviewed the evidence in light

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[5]The Director of the Office of Workers' Compensation Programs did not participate in the proceedings before the ALJ and the Benefits Review Board. After Shahady had filed his petition for review in the court of appeals, the Director moved to amend and reform the caption in order to be included as a respondent. The court of appeals granted the

of the settled rule that factual doubts should be resolved in the claimant's favor in cases of this nature, and prior cases holding that "[w]hen an employee is told by the employer's physician that 'he is recovered from his injury and requires no further treatment, he has, in effect, been refused treatment by the employer' " (Pet. App. 9a). The court "conclude[d] that the ALJ's determination that Shahady was not refused necessary treatment is unsupported by substantial evidence" (*id.* at 10a). It found it unnecessary to decide whether Shahady would have been otherwise required to request authorization for his medical services (*ibid.*). The court also ruled that, in light of the employer's refusal to provide necessary further treatment, the ALJ abused his discretion in refusing to excuse the doctors' failure to file medical reports in a timely fashion (*id.* at 10a-11a).

ARGUMENT

The decision of the court of appeals does not conflict with any decision of this Court or any other court of appeals. Indeed, the court below simply adopted a decision of the Fifth Circuit and established Board precedent, reviewed the evidence, and concluded that the ALJ's determination was not supported by substantial evidence. The court's decision is correct and consistent with the purposes of the LHWCA. Further review by this Court is unwarranted.

1. Section 7(d) of the LHWCA, 33 U.S.C. 907(d), excuses an employee from obtaining authorization for medical treatment as a precondition to reimbursement if the employer has refused to provide or authorize medical treatment. The court of appeals found that Shahady had

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motion, noting in a per curiam opinion that the Director should be named as a respondent in all cases in which judicial review is sought pursuant to 33 U.S.C. 921(c) (Pet. App. 12a-24a; 673 F.2d 479). The Director supported Shahady's position on the merits.

been refused further treatment by Dr. Gibson, the physician to whom he had been sent by his employer. The court rejected the ALJ's contrary determination as unsupported by substantial evidence. The evidence showed that Shahady complained of continued pain in his leg and requested further treatment from Dr. Gibson, but was discharged from further care and told he was " 'fine,' " and " 'there was nothing wrong with [his] leg * * *.' " The ALJ explicitly found that the subsequent treatment was necessary and causally related to Shahady's injury (Pet. App. 9a-10a). This fact-bound conclusion does not justify review by the Court.

2. Petitioners allege that the court of appeals' decision establishes broad principles inconsistent with the congressional intent underlying the LHWCA (Pet. 9-17). In particular, they suggest that "an employee may [now] seek medical treatment on his own without complying with the statute whenever a dispute [with the employer's physician] has arisen" (*id.* at 14; see also *id.* at 9-10). In fact, however, the court of appeals held only that discharge of an employee by a doctor to whom the employer has referred him *may* amount to a refusal by the employer to provide requested medical services. Its decision is the first appellate exploration of the amended Section 7(d) provision for excusing prior authorization. Review of such a question of statutory interpretation, heavily influenced by factual considerations, would be premature without further development in the other courts of appeals.[6]

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[6]The impact of the court's decision even in the District of Columbia is diminished by the recent enactment of the new District of Columbia workers' compensation statute. D.C. Code Ann. § 36.301 *et seq.* (1981). See note 1, *supra*. Injured non-maritime workers in the District will now seek reimbursement under D.C. Code Ann. § 36-307 (1981) rather than Section 7 of the LHWCA.

Moreover, the court of appeals' decision is consistent with the only other appellate decision addressing the same question, under the pre-1972 LHWCA.[7] In *Atlantic & Gulf Stevedores, Inc.* v. *Neuman*, 440 F. 2d 908, 911 (1971), the Fifth Circuit held that "when an injured employee has been told by physicians furnished by an employer that he is recovered from his injury and requires no further treatment, he has, in effect, been refused treatment by the employer, and he needs only to establish that treatment he subsequently procures on his own initiative, was necessary treatment for the injury in order to be entitled to such treatment at the expense of the employer.' "[8] The court's decision is also in accord with a plethora of recent Board decisions recognizing that discharge by a physician may constitute refusal to provide treatment.[9]

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[7]Neither *Maryland Shipbuilding & Drydock Co.* v. *Jenkins*, 594 F.2d 404 (4th Cir. 1979), nor *Nardella* v. *Campbell Machine, Inc.*, 525 F.2d 46 (9th Cir. 1975), is concerned with the effect of discharge by the employer's physician. In *Jenkins* the employee declined to consult with the physician to whom the employer had referred him; in *Nardella* the employee never requested treatment from the employer and the employer did not refer the employee to any physician.

[8]Although *Neuman* was decided before the effective date of the 1972 amendments, the amendments did not change the substantive effect of Section 7(d). Under both versions of that section the employee must request the employer to provide or authorize treatment before seeking treatment on his own initiative. The *Neuman* court specifically excused the employee's failure to notify the employer that he intended to seek further medicial treatment after discharge by the employer's physician. Before 1972, Section 7 did not allow the employee an initial free choice of physician, but did require the employer to maintain a "panel" of physicians in the community from which the employee could choose an attending physician. Pub. L. No. 86-757, Section 7(b), 74 Stat. 900.

[9]See, *e.g.*, *Shell* v. *Teledyne Movible Offshore, Inc.*, 14 Ben. Rev. Bd. Serv. (MB) 585, 590 (1981), aff'd mem., No. 81-4487 (5th Cir. Dec. 9, 1982); *Walker* v. *AAF Exchange Service*, 5 Ben. Rev. Bd. Serv. (MB) 500, 509-510 (1977); *Buckhaults* v. *Shippers Stevedore Co.*, 2 Ben. Rev. Bd. Serv. (MB) 277, 279-280 (1975); *Kilson* v. *Sun Shipbuilding & Dry Dock Co.*, 2 Ben. Rev. Bd. Serv. (MB) 172, 175-177 (1975). The Board

Contrary to petitioners' assertion (Pet. 9-17), the court of appeals' decision is entirely consonant with the congressional intent underlying the 1972 amendments to the LHWCA. The stated purposes of the amendments were to "[meet] the needs of the injured employee and his family" and to "assur[e] that the employer bears the cost of unsafe conditions * * *." H.R. Rep. No. 92-1441, 92d Cong., 2d Sess. 1 (1972). See also *Voris* v. *Eikel*, 346 U.S. 328, 333 (1953) ("[t]his Act must be liberally construed in conformance with its purpose, and in a way which avoids harsh and incongruous results"). By ruling that an employee's discharge by an employer's physician may constitute a refusal to furnish necessary medical services, the court of appeals properly placed the responsibility for medical misjudgment on the responsible party. The decision does not, as petitioners suggest (Pet. 14-16), strip the Deputy Commissioner of his supervisory power by allowing employees to disregard the requirements of prior authorization and written consent to change physicians in all cases in which a medical dispute has arisen. The employee must still show that his post-discharge treatment was both "necessary" and "causally related" to his injury in order to recover (Pet. App. 10a, 46a-47a).

3. Petitioners also maintain (Pet. 22-24) that the court of appeals unjustifiably excused Shahady's physicians' failure to comply with the medical reporting requirements of Section 7(d). Section 7(d) states that a physician's failure to file a report within ten days may be excused by the Secretary in

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has recognized, however, that discharge is not always tantamount to a refusal to provide treatment. See, *e.g.*, *Betz* v. *Arthur Snowden Co.*, 14 Ben. Rev. Bd. Serv. (MB) 805, 809 (1981); *Scott* v. *C & C Lumber Co.*, 9 Ben. Rev. Bd. Serv. (MB) 815, 824 (1978); *Rogers* v. *Pal Services*, 9 Ben. Rev. Bd. Serv. (MB) 807, 811 (1978); *Jackson* v. *Navy Exchange Service Center*, 9 Ben. Rev. Bd. Serv. (MB) 437, 439 (1978).

the interest of justice. The court of appeals held that, by not excusing the failure to file timely reports, the ALJ had abused his discretion. That ruling followed directly from its holding that the employer had refused to provide further treatment and from the Board's own precedent[10] establishing that in such circumstances, failure to file timely reports may be excused (Pet. App. 11a). Such a narrow ruling concerning the exercise of discretion does not warrant further review by this Court.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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[10] *Buckhaults* v. *Shippers Stevedore Co.*, *supra*, 2 Ben. Rev. Bd. Serv. (MB) at 280.

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JAMES R. SHAHADY

AND

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS, U.S. DEPARTMENT OF LABOR,
Respondents.

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DIRECTOR, OFFICE OF WORKERS' COMPENSATION
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Respondents.

REPLY BRIEF

ARGUMENT

I

THE RESPONDENTS' CHARACTERIZATION OF THE CASE BELOW AS "FACT BOUND" IS ERRONEOUS

The Federal Respondent in its brief in opposition states that the finding below is "fact bound" and a "narrow ruling concerning the exercise of discretion". Brief in Opposition, at 6, 9. Yet when the opinion below was initially filed as an unpublished memorandum, the Federal Respondent filed a Motion for Reconsideration of Decision Not to Publish Memorandum Opinion, in which it stated as follows:

> The Court's disposition of this case resolves an important question under the Longshoremen's Act, namely, whether the constructive-refusal doctrine of *Atlantic & Gulf Stevedores, Inc. v. Neuman*, 440 F.2d 908 (5th Cir. 1971); has continued vitality subsequent to the 1972 amendments to the Longshoremen's and Harbor Workers' Compensation Act, and constitutes the only judicial precedent on that question.

Motion filed June 17, 1982, at 1-2.

The Federal Respondent's belatedly expressed view of the decision below as resolving primarily factual issues appears designed to protect the apparently prized precedential value it perceives in the Appeals Court's resolution of the "important question" rather than to relieve this Court from entering into a factual fracas.

II

THE FEDERAL RESPONDENT'S CHARACTERIZATION OF THE HOLDING BELOW IS MISTAKEN

The Federal Respondent characterizes the Court of Appeals holding below in terms suggesting it to have far less reach than it actually has. The Federal Respondent states that:

> . . .the court of appeals held only that discharge of an employee by a doctor to whom the employer has referred him *may* amount to a refusal by the employer to provide requested medical services.

Brief in Opposition at 6. (Emphasis in original.) Federal Respondent characterizes the Board's excusal for failure to file medical reports as follows:

> That ruling followed directly from its holding that the employer had refused to provide further treatment and from the Board's own precedent establishing that in such circumstances, failure to file timely reports *may* be excused.

Brief in Opposition at 9. (Emphasis added.)

To the contrary, however, the Court of Appeals holding was not of the permissive variety, such that reporting *may* be excused or that discharge from medical care *may* amount to refusal of medical care. Rather, in reversing outright the opinion below, the Court of Appeals *mandated* a holding that upon the happening of a certain event (i.e. being "told" by "the employer's physician"[1] that he needs no further care) a claimant is freed from the terms of the statute to seek medical treatment on his own initiative and later reporting requirements are excused *as a matter of law*. (App. 9a, 11a) The suggestion that the holding below merely permits certain legal conclusions, therefore, seriously understates the thrust and nature of the Court's ruling.

III

RESPONDENTS INTERPRET THE SCOPE OF THE DECISION BELOW TOO NARROWLY

It is quite obviously in Respondents' interest at this stage of the proceeding to suggest a narrow interpretation of the Court of Appeals' holding and in a casual fashion belittle

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[1]The concept of employer's physician has no foundation in statutory law, and no defined meaning elsewhere. Private Party Respondent's attempt to justify it by Section 14N of the Restatement, Second, of Agency is meritless on its face, particularly in light of the fact that a physician's medical judgment cannot be considered to be under the control of an insurance company. Brief of Private Party in Opposition at 16-17.

the importance of the case in an effort to convince this Court that it is simply not of sufficient concern to command the scrutiny and attention of the Supreme Court. Respondents' efforts in this regard, however, write into the opinion below limiting factors which simply are not there.

The Court of Appeals did not delve into a factual issue, the resolution of which depended upon unique juxtaposition of factual innuendo. Rather, it created an unyielding rule of law that if a physician initially selected by the employer and carrier *tells* a claimant at any time that he needs no further care, then the regulations and statutes pertaining to medical reporting and change of physician no longer apply.[2]

A reading of the Court of Appeals' decision indicates that this holding would apply (1) even if the employer and carrier had never been directly confronted with a request for treatment; (2) regardless of whether the physician was performing a single independent medical examination or had successfully conducted a lengthy or complicated course of treatment for the claimant; (3) regardless of whether the physician was available for follow-up treatment for as long as the claimant "wanted to come" (App. 9a); and (4) to permit the claimant to consult numerous other physicians even if he already had his own initially and freely chosen physician to whose treatment the employer and carrier had never objected.

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[2]Respondents suggest that the court merely adopted the Fifth Circuit ruling in *Atlantic & Gulf Stevedores, Inc. v. Neuman*, 440 F.2d 908 (1971). Brief for the Federal Respondent in Opposition, at 7, 8; Private Party Respondent's Brief in Opposition, at 15-16, 18. To the contrary, however, in *Neuman*, the claimant had ceaselessly exhausted *all administrative avenues* for relief before seeking treatment on his own, while here, the claimant exhausted *none* of the administrative remedies, and is seeking *excusal* from the terms of the statute.

These factors combine to result in practical application of the doctrine announced below to all cases in which there is a difference in medical judgment between a physician selected by the employer and any physician consulted by the employee. As indicated in the case of *Lloyd v. Slatterly Associates, Inc.*, 15 BRBS 100 (September 30, 1982), filed herein as Appendix J, the Benefits Review Board perceives that to be the appropriate interpretation of *Shahady*, notwithstanding that in *Lloyd*, the alleged employer's physician had not even refused to provide treatment. Respondents studiously ignore this subsequent application of *Shahady*, and their suggested limitations of the decision are inconsistent with its later judicial application.

IV

THE FEDERAL RESPONDENT'S RATIONALIZATION FOR EXCUSING NONCOMPLIANCE WITH THE ACT IS NONPERSUASIVE

The Federal respondent suggests that it is appropriate to excuse all manner of compliance with the medical provisions of the Act if it is later determined that the medical treatment procured was "necessary" and "causally related" to the employment injury. Brief in Opposition at 6, 8.

This point underscores precisely the reason why this case has broad and extensive importance far beyond its borders, reaching into the very core of the administration of the medical provisions of the Act. Federal Respondent seems to be urging that no violence is done to the Act where medical supervision of injured workers is shifted from prior and concurrent supervision of treatment by the Deputy Commissioner to an *ex post facto* review of stale facts at a hearing by an Administrative Law Judge at a time when he can do nothing more in the way of medical

supervision than to direct payment or nonpayment of bills. Surely this refocus and redefinition of the concept of medical supervision is not consistent with the statutory scheme, and is utterly ineffective to rationalize the Court of Appeals wholesale elimination of the administrative provisions of §7 of the Longshoremen's and Harbor Workers' Compensation Act.

V

RESPONDENTS' DEFENSE OF THE COURT OF APPEALS INTERPRETATION OF BUCKHAULTS v. SHIPPERS STEVEDORING COMPANY IS INEFFECTIVE

Respondents are conspicuously weak in their attempt to justify the Court of Appeals interpretation of Benefits Review Board precedent of *Buckhaults v. Shippers Stevedoring Company*, 2 BRBS 277 (1975). This is quite understandable since there is no arguable basis to justify that portion of the Court of Appeals' holding. Private Party Respondent's rationalization for the Court of Appeals is as follows:

> Requiring filing of the medical reports after a refusal would not aid the employer or Deputy Commissioner. To expect a claimant to have reports sent to the employer by an unauthorized physician would place an unreasonable burden on the claimant.

Private Party's Brief in Opposition at 20, n.9. While this circular reasoning – that it is unreasonable to require a claimant to start complying with the Act after he has already sought treatment outside its provisions – is catchy, it is not persuasive.

CONCLUSION

Respondents' casual attempts to suggest the limited applicability of the case below are baseless. A Writ of Certiorary should issue.

Respectfully submitted,

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